# STATE TITLE V BLOCK GRANT NARRATIVE
# STATE: CA
# APPLICATION YEAR: 2006

# I. GENERAL REQUIREMENTS

## A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

## B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

## C. ASSURANCES AND CERTIFICATIONS

See the attachment for the State of California's Assurances and Certifications and Memorandums of Understanding.

## D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

## E. PUBLIC INPUT

An abridged draft of the FFY 2006 Application/Report, including data tables, was posted on the Maternal, Child, and Adolescent Health (MCAH) Branch website for review and comment. MCAH partners, including local MCAH Directors, contractors and other stakeholders were advised of the availability of the draft. The Children's Medical Services (CMS) Branch added a Title V link on the CMS website that connected to the MCAH website and made the draft Application/Report available to its partners. A CMS Information Notice was placed on the CMS Website informing stakeholders, including the California Childrens Services (CCS) administrators, local Child Health and Disability Prevention (CHDP) program directors, deputy directors and medical consultants, and CMS Branch staff, about accessing the draft Application/Report.

See the attachment to this section for more information about Public Input. Responses to last year's Grant Recommendations are also included in the attachment.

## II. NEEDS ASSESSMENT

In application year 2006, the Needs Assessment must be provided as an attachment to this section.

# III. STATE OVERVIEW

## A. OVERVIEW

### Demographics

California is the most populous of all US states, with 36.6 million residents as of July 2004, and is the third largest state in terms of land area. [1] The state's population has increased annually since 1940 and currently makes up 12 percent of the nation's total. Though the population in the state continues to increase, the rate of increase has slowed each year since 2000, from 2.0 percent in 2000-2001 to 1.7 percent in 2003-2004. [2]

The population increase is the result of a net increase of births minus deaths plus net migration to the state. Foreign immigration to the state far exceeded domestic migration for the period 1999-2004, with net foreign immigration totaling 1,228,673 and net domestic migration totaling 435,290. [3]

California residents are younger on average than the nation as a whole. The median age for the state in 2003 was 34, which is significantly lower than the median age in the US of 36. [4]

In 2003, there were almost 7.8 million women of childbearing age (15-44) in California. [5] Women of childbearing age represent 22 percent of the state's total population. The 10.2 million children under age 19 account for 29 percent of the population, including 2.5 million under the age of 5 (7 percent), and over 500,000 under one year (1.5 percent). [6] Nationally, children under age 19 make up 28 percent of the population, and those under 5 make up 7 percent. Between 2003 and 2009, the female teen population (ages 15-19) in California is projected to increase by 14 percent, and the Hispanic teen female population is projected to increase by 28 percent. [7]

The number of live births in California increased from 518,073 in 1999 to 540,827 in 2003. [8] While the overall number of births in California has been increasing, the number of teen births declined from 56,577 in 1999 to 49,330 in 2003. The rate of teen births (per thousand females age 15-19) has dropped from a peak of 72.9 in 1991 to 38.9 in 2003.

Although the overall teen birth rate declined steadily between 1991 and 2003, the decline among Hispanic teens was slower, and Hispanics are disproportionately represented in the number of California's teen births. Hispanics account for 69 percent of teen births [9], while only accounting for 41 percent of the total teen population (age 15-19). [10]

### Diversity

In addition to its overall population expansion, California continued to experience growth in its ethnic diversity. The fastest growing group is Hispanics. Hispanics, as a proportion of the state population, increased from 26 percent in 1990 to 32 percent in 2000. [11] By the year 2040 the percentage of Hispanics is projected to reach 54 percent, making it the majority ethnic group in the state, as well as the majority ethnic group for twenty counties. [12] In 2000, Whites comprised 47 percent of California's population, followed by Hispanics (32 percent), Asian/Pacific Islanders (12 percent), African Americans (7 percent), and American Indian/Alaska Natives (1 percent).

California is home to 28 percent of the nation's foreign-born population. In 2002, 27 percent of the nation's immigrants settled in California. Nearly half (49 percent) of these immigrants were born in Latin America and the Caribbean, primarily Mexico, and 39 percent were born in Asia. [13]

In California, Hispanics are younger on average than members of other racial/ethnic groups, and this age differential is increasing. The median age of Hispanics in California in 2003 was 26, eight years younger than that of the total population (34). Among Whites, the median age was 40, and for Asian and Pacific Islanders, the median age was 34. [14] Hispanic children comprised the largest proportion of school children during the 2003-2004 school year, making up 46 percent of students in California.

[15]

Racial/ethnic diversity and a large immigrant population contribute to linguistic diversity in California. In 2003, 41 percent of California residents over the age of five spoke a language other than English at home, compared to 18 percent nationwide. Most often this language is Spanish, however, a variety of Asian and Pacific Island languages are also spoken. Of those who speak a language other than English at home, 47 percent believe that they speak English less than "very well." [16] This poses a linguistic barrier to access to health services in California. Nearly half of Medi-Cal and Healthy Families recipients in 2003 spoke a language other than English. [17] To increase access, Medi-Cal and Healthy Families publish materials in ten different languages.

## Geography

California is comprised of 61 local health jurisdictions, including 58 counties and three incorporated cities. These local health jurisdictions vary widely in geographic size, number of residents, and population density. In terms of geographic area, San Bernardino is the largest county, and San Francisco, San Mateo, and Marin Counties are the smallest. Los Angeles County is the largest in terms of population, with over 10 million residents, 28 percent of the state's total population. Alpine County had the smallest population, with 1,210 residents.

Most of the state's population (94 percent) resides in urban areas. Los Angeles, San Diego, Orange, Santa Clara, and San Francisco Counties all have large urban populations. Some counties, such as Fresno, Monterey, and Santa Barbara, are primarily rural but contain urban centers where most of the population resides.

Most counties in the state experienced population growth between 2000-2004, although the rate of growth appears to be slowing. [18] Riverside and Placer Counties grew at the highest rate, increasing in population by at least 4 percent each year. Other counties projected to experience large increases in population include San Joaquin, Merced, and Madera.[19] From 1999-2004, Sierra was the only county with a net loss in population, but Alpine and Marin Counties were at or close to a zero growth rate. [20]

In addition to the variation in population size among counties, there are abundant differences in geographic terrain. Rural counties may be agricultural, mountainous, desert, forested, or any combination thereof. Some counties contain pockets of population in certain areas that can readily access health services, while those residing in other parts of the county may face significant barriers to access. Impassability of roads, due to weather conditions, may also make access to services impossible during parts of the year in some counties. Rural counties' community assessments provide many illustrations of geographic barriers to healthcare.

Other counties noted deficiencies in, or a complete lack of, public transportation, making access time-consuming and complicated for those without their own means of transportation. Mendocino County, for example, reported that some transit routes from remote areas to services in larger towns such as Ukiah or Fort Bragg could take over an hour in each direction, and may only run one round trip per day, providing little flexibility for residents who rely on them for access to services.

## Economy

In 2003, the State of California's gross product ranked seventh in the world. [21] This is in spite of the fact that California has not shared completely in the economic growth the nation has experienced recovering from the recent economic recession. California's unemployment rate in 2004 was 6.1 percent, compared to the national rate of 5.5 percent. The drop in the unemployment rate in Fiscal Year (FY) 2003-04 was the first drop in unemployment since FY1999-2000. [22] The forecast through 2007 projects that California's unemployment rate will not fall or change significantly, suggesting that

the slow pace of economic growth in the state will continue. [23]

The stagnant economy in the state has resulted in budget cuts that have affected maternal and child health programs and services. The state has experienced restrictions on the creation of new contracts, purchasing of equipment, hiring of staff, and travel. This has curtailed the ability of State programs to provide technical assistance and training to local health jurisdictions, compromising the ability to improve and sustain program quality.

Restrictions on State programs and services compound existing challenges faced by California's residents who live near or below the federal poverty level (FPL). The US Census Bureau estimates that in 2003, 13.4 percent of California residents lived below the FPL. This is worse than the national rate of 12.7 percent and ranks California as the 19th worst state in terms of residents in poverty. [24] Two counties in California's Central Valley ranked among the ten most impoverished counties in the nation: Tulare, with 22.9 percent of residents living below the federal poverty level, and Fresno, with 21.8 percent. [25]

The federal definition for low-income is household income of less than 200 percent of the poverty level; however, in parts of California, the high cost of living creates stress for families whose incomes are not necessarily low by this definition. In 2003 California ranked 48th in the nation for home ownership among residents. It ranked second in the nation for cost of a home or rental contract. [26] Of those families with children in California whose income falls below 150 percent poverty level, 33 percent are headed by a single female parent. [27] Of the 4.6 million households with one or more children under 18 in California, 20 percent are headed by a single female parent. [28] These households are more likely to struggle to support themselves with less than adequate income.

Housing costs present an increasing challenge in California, both for those who rent and for those who hope to own their home. The population growth occurring in California only compounds this problem, as the construction of new housing units cannot keep up with increasing demand. While the actual cost of housing varies between different regions in California, the problem exists throughout the state.

In high-cost Orange County, 48 percent of renters and 32 percent of owners spent more than the recommended 30 percent of their household income on housing. Among low-income (less than $20,000/household) residents, this proportion balloons to 89 percent of renters and 80 percent of those who own their homes. In San Francisco, to afford a two-bedroom apartment at fair market rent (as deemed by the Federal Housing and Urban Development Office), a family needed to earn $71,000, the equivalent of five minimum wage jobs. [29]

Orange and San Francisco Counties are notoriously high-cost areas; however, even in lower-cost areas, affordable housing is becoming increasingly scarce. In California's rural counties, a family would need to earn $10/hour (153 percent of minimum wage) working full-time in order to afford a Fair Market Rent apartment ($537/month for a two bedroom apartment). [30]

Homelessness is also an ongoing problem for the state. For example, in Alameda County, an estimated 12,000 people are homeless on a given night, and approximately 40 percent of those are families with children. [31]

Single parenthood, low income, and high housing costs, along with welfare reform, force most women with children into the labor force. Of the almost 6.5 million women in California between the ages of 20 and 44 (as of March 2004), 70 percent participated in the labor force. [32] In California, 52 percent of children were in families headed by a single working parent or in which both parents worked. [33]

The proportion of women in the labor force, coupled with the number of single-parent households in California, creates an enormous need for childcare for working parents. Unfortunately, licensed childcare is available for only 25 percent of children with parents in the labor force. The cost of childcare for a preschooler typically consumes 48 percent of a parent's income if the parent is working

full time at minimum wage. [34]

Hispanics and African Americans are disproportionately low income. The 2003 median household income was $36,000 for Hispanics and $40,000 for African-Americans, both well below the state's median household income of $49,320. The median household income for Whites and Asians was $71,474 and $67,064 respectively. The proportion of California residents living in poverty (<100 percent FPL) shows similar racial/ethnic disparities: 22 percent for African Americans, 21 percent for Hispanics, 11 percent for Asians, and 8 percent for Whites. Fifty percent of Hispanics and 43 percent of African Americans were classified as low income (<200 percent FPL). [35]

Income level correlates with education level in California, as it does nationally. The median number of years of education completed by California's residents 25 years or older is 13.5. Among California residents, 81 percent have a high school diploma, and 32 percent have a Bachelor's degree or higher. Asians have the highest rate of college completion among California residents, at 50 percent, followed by Whites at 40 percent, African-Americans at 23 percent, and Hispanics at 10 percent. The high school graduation rate was 94 percent for Whites, 87 percent for African-Americans, 85 percent for Asians, and 54 percent for Hispanics. [36]

There are currently more than 6 million school-aged children in California and more than 9,000 schools. [37] Hispanic students comprise the largest and fastest growing racial/ethnic groups in California schools. Of the student population, 49 percent receive subsidized school lunches. Over one quarter are classified as English learners; most of these English learners' first language is Spanish. [38]

Health Care Status

In California, 18 percent of the population did not have health insurance in 2002, compared to 15 percent of the US population. Among California's Hispanic population, 31 percent were uninsured. Among California children under the age of 18, 14 percent were uninsured. Among California children, 28 percent were covered by Medicaid or Healthy Families, compared to 25 percent for the US. [39] Among the poor and low-income population in California, children were more likely to be covered by public programs than adults. Continuing to raise the rates of enrollment in public insurance programs, especially among immigrants and non-English speaking populations, remains a challenge for the state.

Another challenge for the state is meeting the health care needs of the large number of undocumented immigrants, many of whom are migrant workers. While the number of undocumented immigrants in California is difficult to measure, a recent study suggested that 2.4 million undocumented immigrants were in the State of California in 2002, over a quarter of the nation's estimated 9.3 million. [40] It is estimated that 40 percent of the undocumented immigrants are women. In one sample of undocumented immigrants in Fresno and Los Angeles Counties, half were between the ages of 18 and 34, and one quarter were children under 18. [41]

Most of the undocumented families lack employer-based health insurance, and many are prevented from accessing publicly funded insurance due to legal and regulatory restrictions. Providing MCAH services to this population presents a unique challenge which is made even more difficult by the different eligibility requirements for available public programs. Some services, such as WIC, are available to undocumented immigrants. Others, such as Medi-Cal, are available to undocumented immigrants on a limited basis. Still others, such as Food Stamps, are not available to undocumented immigrants, but are available to their children born in the United States.

It is not surprising, given the complicated nature of eligibility for public assistance, coupled with fear of the consequences of having to reveal one's status as undocumented, that access and participation in available services among the undocumented population is very low. Still, the most common reason given by undocumented immigrants for not seeking health care was that it was too expensive. [42]

Other complications arise for undocumented immigrants who seek services in one county, then move on to another region for work. This makes it difficult to provide consistent and comprehensive services and to track services rendered to this population.

Challenges in meeting the diverse needs of mothers and children also arise as a result of increasingly varied family and household structures that exist in California. For example, in addition to the large proportion of female-headed households with children, a growing proportion of children are living with grandparents. In 2003, over 860,000 grandparents stated that grandchildren were living in their home. In 31 percent of these households, the grandparents reported that they were the primary caretakers for the grandchildren living in the household. Of those responsible for grandchildren, 55 percent were working, and 16 percent were living in poverty. [43]

The aging of the state's population also has an impact on the health and well-being of mothers and children. In California, 16 percent of all households contain at least one caregiver for someone aged 50 or older. Three quarters of those caregivers are women, and 31 percent have their own children living at home. [44] This can pose a financial and emotional burden on families, particularly those who are low-income and/or have working mothers. About half of California caregivers reported they were employed, 35 percent full-time. One third of caregivers reported high emotional stress due to providing care. Addressing this growing stress on families is likely to become an increasing challenge in the future, as the proportion of the population over age 50 grows and the cost of living forces many households to consolidate and increase in size.

The diverse nature of California's population and geography, coupled with the changing face of the population demographically, socially, and economically, proves to be a continuing challenge for the programs of California's Maternal Child and Adolescent Health / Office of Family Planning (MCAH/OFP) Branch and Children's Medical Services (CMS) Branch.

Major State Initiatives

> Early childhood development

Proposition 10, the Children and Families First Act (implemented in 1998), imposes a surtax on cigarette sales, which generates revenues of about $600 million a year. The state-level commission, First Five California, receives 20 percent of the funds, while local First Five Commissions in each of the 58 California counties receive 80 percent. First Five California has devoted $207 million over four years (2002-2006) to its signature School Readiness Initiative (SRI). Health and social services are essential elements of SRI.

First Five has four other efforts addressing early health. They are 1) Childcare Health Linkages; 2) The Infant, Preschool and Family Mental Health Initiative; 3) the Childhood Asthma Initiative (CAI); and 4) the Oral Health Initiative. The MCAH/OFP Branch follows the activities of First Five and helps local staff prepare SRI proposals and identify the connections between their programs and First Five activities.

As part of the CAI, the CMS Branch received a grant of approximately $1 million for FY 2004-05 to develop an asthma curriculum and provide educational support to pre-school and child care providers in order to improve the asthma outcomes for children in child care. This final year of the grant includes educating Child Health and Disability Prevention (CHDP) providers about asthma and reinforcing the requirement that asthma screenings occur as part of the CHDP providers' health assessments. CHDP providers serve nearly 1.3 million children under five years of age.

In addition, MCAH/OFP received a two-year planning grant for 2003-2005 from the federal Health Resources and Services Administration (HRSA) for the State Early Childhood Comprehensive Systems (SECCS) project. MCAH/OFP will provide state-level leadership for early childhood health programs to help California's children be emotionally, socially, and physically ready for kindergarten.

The grant will culminate in a statewide needs assessment and strategic plan to address critical components of early childhood health care systems. The planning grant will be followed by a multi-year implementation grant starting in FY 2005-06.

> Child health insurance coverage

Another major state initiative is improving the health of the Title V population through expanded health insurance coverage. Efforts to increase enrollment in the state-sponsored children's health care programs, including Medi-Cal and Healthy Families, appear to be reducing the percentage of uninsured children.

Since the inception of the CHDP Gateway in July 2003 and through March 2005, over 1.2 million children receiving CHDP assessments have been pre-enrolled for up to two months of no cost full-scope Medi-Cal benefits. Families of 80 percent of these pre-enrolled children have requested joint applications from Medi-Cal/Healthy Families (HF). Of these, 28 percent completed the application process and 16 percent had their eligibility extended for Medi-Cal/HF.

Effective June 2004, the CHDP Gateway was enhanced to allow deeming of Medi-Cal eligibility for infants if their mother's eligibility for Medi-Cal at the time of birth was confirmed. Eligibility is extended until the first birthday without requiring their parent(s) to complete a joint Medi-Cal/HF application. In the first nine months, 42,837 infants were automatically enrolled in Medi-Cal as the result of a Gateway transaction.

> Oral health promotion

The California Department of Health Services (DHS) is responding to the high prevalence of dental disease among California's children with a variety of strategies to increase awareness of oral health. MCAH/OFP Branch staff work to ensure the inclusion of oral health promotion activities within existing programs of the Branch. Comprehensive Perinatal Services Program (CPSP) guidelines have been revised to include oral health guidelines for pregnant women, infants, and children. Toothbrushes and children's fluoride toothpaste have been distributed to domestic violence shelters as well as local MCAH programs including the Adolescent Family Life Program (AFLP), Black Infant Health (BIH), and CPSP as incentives and education tools.

The MCAH/OFP Branch is contracting with University of California San Francisco (UCSF) for an oral health epidemiologist and a dental hygienist to serve as MCAH/OFP Oral Health Policy Consultants to meet the growing demand for technical assistance at both the state and local levels. The contract is awaiting state approval. The Oral Health Policy Consultants will work with Branch programs as well as being involved with the State First Five Commission.

The California First Five Commission has developed an Oral Health Initiative which consists of 1) a $7 million Early Childhood Oral Health Education and Training Project, and 2) a $3 million Insurance-Based Oral Health Demonstration Project. Provider training began in 2004 and will last for the four years of the grant.

The California Office of Oral Health (OOH) is partnering with the MCAH/OFP Branch and the Dental Health Foundation to conduct a statewide Oral Health Needs Assessment (OHNA). Data from the OHNA will help the MCAH/OFP Branch to monitor Title V National Performance Measure (NPM) 09 relating to the prevalence of sealants on 3rd grade children.

In FY 2002-03, 1,809,906 children received dental screenings through the CHDP program, an increase of 4 percent from FY 2001-02.[45] There are challenges for the California Children's Services (CCS) program due to the shortage of Denti-Cal dentists, orthodontists, and other dental subspecialties; this is impacting the ability of the CCS program to provide needed services to children

eligible for CCS. CMS Branch staff are meeting with Denti-Cal to work on solutions for improving access to dental/orthodontic care for these children and youth.

> Preventing childhood obesity

California, like the nation, is experiencing an increase in the prevalence of obesity and related health problems. The DHS Director has established a DHS Nutrition and Physical Activity Action Team with representatives from both MCAH/OFP and CMS. The Action Team has proposed a $6 million Obesity Prevention Initiative consisting of community action projects, a health quality collaborative, tracking and evaluation of data, worksite interventions, and public awareness and education activities. Both MCAH/OFP and CMS are also involved in the Physical Activity and Nutrition Coordinating Committee (PANCC).

Childhood obesity in low-income children is assessed through the Pediatric Nutrition Surveillance System (PedNSS) data that are now on-line on the CMS Branch website. Data for 2003 show that the percentage of low-income children under 5 years receiving healthcare through CHDP who are overweight is unchanged from 2002 at 16.2 percent. For children 5 to 20 years, the percentage overweight has increased from 20.8 percent (2002) to 21.7 percent. For children 2 to 5 years, the prevalence for at-risk-for-overweight is steady for the past few years at 16.2 percent. For children 5 to 20 years, the prevalence for at-risk-for-overweight increased from 18.1 percent (2002) to 18.4 percent. Ethnic variation in the prevalence of overweight still exists, with the highest prevalence in American Indian/Alaskan Native, followed by Hispanic children. [46]

The MCAH/OFP, CMS, and WIC Branches of DHS and the UC Berkeley Center for Weight and Health collaboratively hosted the third biannual California Childhood Obesity Conference entitled, "Launching a Movement: Linking Our Efforts to Make a Difference" in January 2005 in San Diego. Over 1,400 attended this conference. The next conference is in January 2007.

MCAH/OFP programs, including AFLP, the Adolescent Sibling Pregnancy Prevention Program (ASPPP), BIH, California Diabetes and Pregnancy Program (CDAPP) and CPSP, promote healthy eating, physical activity, and breastfeeding. The former School Health Connections Program, now known as MCAH in Schools program, continues to support and promote a comprehensive school health system, including physical education and healthy food choices.

The California Nutrition Network for Healthy, Active Families is a public/private partnership led by DHS. The purpose of the Network is to promote healthy eating and a physically active lifestyle among low income Californians by using social marketing techniques to reach large numbers of people. In addition to DHS, Network partners include the Department of Social Services (DSS), the Department of Education (CDE), the Department of Food and Agriculture, and the University of California (UC) Cooperative Extension.

The MCAH/OFP Branch has been funded by the Nutrition Network to undertake projects in two counties, Contra Costa and Fresno. In Contra Costa County nutrition education and information will be provided to AFLP, BIH, CPSP, and Cal-Learn participants as well as in eight elementary schools and one middle school. In Fresno County, the project involves the development of a toolkit and training for providers who serve low-income families with young children. The toolkit will include written materials and video in English, Spanish and Hmong.

CHDP local programs in Yolo and Sonoma Counties have been funded by the Nutrition Network for Special Projects in 2004-2005. Yolo County is developing a video series (for agencies, providers and local public cable channel) of cooking demonstrations in English and Spanish that will show how to incorporate fruits and vegetables into main dishes, breakfast items, snacks, and side dishes. The County is developing a culturally sensitive in-service training for CHDP providers to increase their knowledge and skills to intervene with low-income children and their families at risk for obesity.

Sonoma County, in addition to actively participating in the Family Nutrition Activity Task Force, is targeting 100 food stamp eligible children (and their parents) identified as "at risk" for developing diabetes and hypertension to receive culturally appropriate education aimed at promoting an active lifestyle and healthy eating habits. The Sonoma CHDP program is coordinating the President's Fitness Day activity of gathering height/weight data on fifth graders at eleven Sonoma County schools to identify the broad picture of County overweight status and establish a baseline for following future trends.

> Eliminating racial and ethnic disparities in health

Racial and ethnic disparities continue to exist in the areas of infant mortality, neonatal mortality, preterm delivery, low birth weight and maternal mortality in California. The MCAH/OFP Branch makes cultural sensitivity a cornerstone of every program activity, including AFLP, ASPPP, the Battered Women's Shelter Program (BWSP), BIH, CDAPP, and CPSP.

CDAPP incorporates cultural competence awareness in all CDAPP trainings and materials. At-risk women, including Hispanic, African American, and Asian/Pacific Islander women, are targeted. Direct services are provided by a well-trained, ethnically diverse work force of diabetes and pregnancy specialists. Food plans are developed to include foods that are compatible with the dietary customs of each client.

California's BIH programs have served as a national model by successfully identifying and enrolling the highest risk population, pregnant and parenting African-American women, for focused interventions. Comprehensive services offered to this population include the development of client-centered, culturally sensitive education, case management, and prenatal and pediatric care.

State outreach efforts have been designed to reduce the disproportionately high rates of uninsured among California's ethnically diverse populations. To improve access to Medi-Cal services, all Medi-Cal Managed Care (MCMC) materials are to be made available in ten threshold languages: Spanish, Chinese, Vietnamese, Cambodian, Hmong, Laotian, Korean, Russian, Farsi, and Tagalog.

Local communities work to achieve cultural competency and reduce health disparities. In Contra Costa County, the Perinatal Service Coordinator has conducted an Ethnic Diversity Training Day to engage medical and health care providers to provide culturally sensitive care. The Contra Costa County Health Department has distributed the Steps to Take (STT) Guideline Client Handouts and Sudden Infant Death Syndrome (SIDS) materials in several languages. Similar efforts have been undertaken in Solano County.

> Adolescent health promotion

The State has formed the California Initiative to Improve Adolescent Health, based on the National Initiative to Improve Adolescent Health by the Year 2010. In response to the interest among county MCAH directors and local agencies, the MCAH/OFP Branch contracted with the National Adolescent Health Information Center (NAHIC) at UCSF to work with local programs to promote the plan and provide technical assistance in the development of activities.

NAHIC produced the Guide to Adolescent Health Data Sources to assist local MCAH Directors and others interested in adolescent health to better assess the needs of youth in their community. In addition, a California Adolescent Data Update on Intentional and Unintentional Injury was developed for dissemination at the California Conference on Childhood Injury Control.

The California Adolescent Health Collaborative (AHC) continues to be a vital forum for local MCAH/OFP programs, community programs and providers, and state agencies to share information on important adolescent health activities and provide up-to-date training on specific issues. AHC has

provided informative updates on Prop 63 (Mental Health Services Act) and other youth-related mental health issues through their Mental Health Policy Newsletter and other special forums, including meetings of the local MCAH Directors.

In collaboration with the Association of Maternal and Child Health Programs (AMCHP), NAHIC, and AHC, the MCAH/OFP Branch met with local and state stakeholders to assess the Adolescent Health System Capacity for the MCAH/OFP Branch in April 2005. The Branch will use this information to prioritize and plan adolescent health programs and projects for the future.

The MCAH/OFP Branch funds domestic violence shelters that have provided trainings to enable youth to foster healthy relationships, obtain feedback to identify gaps in services, work as peer counselors, and serve on advisory boards.

> Foster care

Children and youth in foster care settings are high-risk individuals who often do not receive necessary health care evaluations and services. California has over 84,000 foster children. To improve access to and oversight of health care for these children, the Health Care Program for Children in Foster Care (HCPCFC), a collaboration between DSS and CMS, was initiated in January 2000. This program, administered locally by the CHDP program, places public health nurses (PHNs) in administrative case management positions in welfare service agencies and probation departments to assure delivery of comprehensive preventive, diagnostic and treatment health services to children and youth in foster care and to serve as a resource on the unique health care needs of children and youth.

The foster care PHNs have formed a Statewide Foster Care Executive Subcommittee (of the CHDP Executive Committee) which serves the function of providing leadership to promote standardization of nursing practice in Child Welfare and Juvenile Probation in California. The Subcommittee advises the Executive Committee on program issues relating to the goal of increasing access to preventive health, dental, developmental and mental health services for children and youth in foster care. The Subcommittee provides a link to the five Regional Foster Care PHN groups through its membership, dissemination of minutes, and sharing of information relevant to health services for children and youth in foster care.

The HCPCFC PHN directory is online at www.dhs.ca.gov/pcfh/cms/hcpcfc/. It provides contact information for PHNs and supervisors and a calendar of events, including regional meetings and statewide subcommittee meetings.

>Safe motherhood

Each maternal death is tragic and represents a premature loss of life. Much of maternal morbidity and "near miss" mortality goes unnoticed by traditional public health surveillance systems and can impact maternal, fetal, and infant health.

Modeled on the California Perinatal Quality Care Collaborative (CPQCC), the MCAH/OFP Branch has developed a Maternal Quality Collaborative (MQC) to address maternal morbidity. CPQCC uses data-oriented quality improvement activities to improve perinatal and neonatal outcomes. The MQC is a collaborative effort between the CPQCC and the UCLA Maternal Quality Improvement Group. The MQC Leadership Council includes members from CCS, MCAH/OFP, MCMC, and Medi-Cal Policy Section. MQC measures maternal quality of care in California and has begun to identify hospital-level outcomes for maternal/neonatal infections and postpartum hemorrhage.

Over the past year, the MCAH/OFP Branch has also developed a Pregnancy-Related and Pregnancy-Associated Mortality Review Project. Maternal mortality ratios remain much higher than the Healthy People 2010 objective and racial and ethnic disparities in mortality are large. The goal of this project

is to is to examine the medical and psychosocial events leading up to death for women who died from pregnancy-related causes or within one year of pregnancy (pregnancy-associated deaths) so that MCAH/OFP Branch and its stakeholders can develop a public health component to reduce such deaths.

The MCAH/OFP Branch is partnering with UCSF and the Public Health Institute (PHI) to conduct this study. The study team will identify sample cases and will abstract medical records for the antenatal, peripartum, and postnatal periods, using forms based on models provided by the CDC. A Case Review Team will review de-identified case summaries and determine whether deaths were due to pregnancy-related factors or linked to the period after pregnancy by time only. MCAH/OFP Branch, UCSF, and PHI will report findings and work with stakeholders to disseminate findings and develop next steps for action.

> Black Infant Health / Fetal Infant Mortality Review

In response to the persistent disparity between African-American and White infant mortality rates, the MCAH/OFP Branch has begun the Black Infant Health/Fetal Infant Mortality Review (BIH/FIMR). The goal of BIH/FIMR is to reduce African American fetal and infant deaths through review of these deaths at the community level. Eight BIH jurisdictions were selected for participation; all had an African-American combined fetal and infant death rate above the average for the 17 BIH jurisdictions statewide, and all have a FIMR program.

BIH/FIMR uses the National FIMR model to collect detailed information about African-American fetal and infant deaths beyond vital statistics. Data will be centrally collected and reportable at the state and county level. The program will train local FIMR coordinators and increase collaborative community involvement through BIH. A state-level BIH/FIMR team will be created to address state-level systemic issues.

BIH/FIMR incorporates the Perinatal Periods of Risk (PPOR) model for case selection and prioritization of prevention strategies. CityMatCH, a national organization of city and county MCH programs representing urban communities in the U.S., provided training on the PPOR model in Sacramento in January 2005. Counties have ongoing access to CityMatCH for further technical assistance. A centralized database system is under development, with the goal of an eventual web-enabled system.

> Preconception care

The MCAH/OFP Branch is collaborating and supporting the efforts of the American College of Obstetricians and Gynecologists, the California Academy of Family Physicians, the March of Dimes, the UCSF Center for Health Policy Studies, and Sutter Medical Center in improving the practice of preconception care.

The California Preconception Care Initiative is developing a provider/patient resource packet to assist health care providers. Covered topics include: smoking cessation; substance abuse, including alcohol; family planning; prevention, diagnosis and treatment of sexually transmitted infections, including HIV; domestic abuse and violence; nutrition, folic acid use, and physical activity; mental health; oral health; optimal blood glucose control among women with preexisting diabetes; screening for hypertension; infections and immunizations, and exposure to medications which increase risk for congenital anomalies. In addition to the packet, clinical information will be disseminated through the Internet, regional conferences, DVD, and audio presentations.

The MCAH/OFP Branch has applied to the Centers for Disease Control and Prevention (CDC) for a Prevention Specialist (PS) for a period of two years to serve as the lead for a Statewide Preconception Health Task Workgroup. The PS and Task Workgroup will develop a statewide plan for

implementing preconception health strategies and interventions. It is expected that the MCAH/OFP Branch will be notified in the summer of 2005 whether the CDC has approved the PS.

> Mental health

California's MCAH/OFP Branch is working to address the mental health needs of infants, children, adolescents, and mothers. The Proposition 63 Mental Health Services Act (MHSA) provides funding for the expansion of mental health services for adults and children using revenue from an additional 1 percent tax on income over $1 million. MCAH/OFP staff participate in the MHSA stakeholder group.

Many MCAH/OFP Branch programs include a mental health component, including AFLP, ASPPP, BIH, CDAPP, CPSP, and DV. All include assessment and referral, and some include treatment as well. Interventions may include counseling for an individual, family or group, and may address psychiatric illness, marital and family problems, alcohol and substance abuse, smoking cessation, depression, eating disorders, etc.

The Domestic Violence (DV) program requires mental health counseling for both adults and children. All agency staff are trained to identify mental health issues and counsel clients, and agencies provide mental health referrals as needed. A collaborative project is underway to develop a curriculum for training local staff to work with women experiencing DV in addition to mental health and/or substance abuse issues.

The MCAH/OFP Branch participates in statewide efforts to implement coordinated mental health services. Three such efforts currently underway are the Behavioral, Emotional, and Social Screening and Treatment for Primary Care Providers (BEST-PCP) Project; the State Early Childhood Comprehensive Systems (SECCS); and the School Readiness Initiative (SRI).

BEST-PCP brings together state agencies, including the MCAH/OFP and CMS Branches, and stakeholders to improve access to services promoting healthy mental development for children age 0-3 who are enrolled in MCMC. A model quality improvement project (including training tool) is being implemented in two counties.

The SECCS project, funded through a HRSA grant, provides state-level leadership for programs that will help California's children to be emotionally, socially, and physically ready for kindergarten. The project coordinates various health-related programs of state and local government with organizations such as the American Academy of Pediatrics (AAP), March of Dimes, Easter Seals, and representatives of faith-based organizations.

The SRI is the signature initiative of First Five California. Mental health counseling is one of the five "essential and coordinated elements" of SRI. It is anticipated that the SECCS initiative will strengthen the health component of the SRI, including mental health.

>Fetal Alcohol Spectrum Disorder (FASD)

An estimated 4,460 to 6,050 babies with FASD are born each year in California. [47, 48] The MCAH/OFP Branch aims to improve birth outcomes for women at risk of alcohol use/abuse, including screening and referral for treatment services. Community-based prevention programs, including CPSP, BIH, AFLP, ASPPP, DV, and CDAPP, provide clients with information about FASD, identify those at high risk, and refer them for alcohol treatment services.

The MCAH/OFP Branch participates in a Statewide FASD Task Force. The Task Force meets quarterly and consists of representatives from state agencies and local communities. Their mission is to encourage best practices for prevention and provide intervention to those affected by FASD.

Many local health jurisdictions are also active in FASD prevention. Fresno County uses federal Healthy Start funds to identify and intervene in the lives of potentially alcohol dependent women. About half of Fresno County's CPSP providers screen for alcohol abuse using Dr. Ira Chasnoff's 4 P's Plus screening instrument. This brief, nationally-recognized tool identifies pregnant women at risk for alcohol and illicit drugs. Fresno County's Black Infant Health and Nurse Family Partnership programs also screen clients for use of alcohol.

Dr. Chasnoff has worked with several other California MCAH/OFP jurisdictions to combat FASD, including Ventura, Madera, and Alameda Counties. Butte County received funds from their local First Five to receive training directly from Dr. Chasnoff. They organized the First Chance Coalition, a community-based group that focused on education, awareness, and intervention.

> Medi-Cal redesign

In 2005-2006 it is projected that Medi-Cal will provide medical services for 6.6 million low-income Californians at a cost of $34 billion, of which $13 billion will be from the State General Fund. In the last seven years Medi-Cal expenditures have increased by 60 percent. Fiscal demands threaten the program's long-term financial viability and jeopardize the State's ability to fund other programs.

Governor Schwarzenegger is proposing to redesign Medi-Cal in order to maintain health care coverage to eligible Californians while containing costs and maximizing operating efficiencies. Some of the redesign initiatives that are under consideration include expansion of managed care (reduction in fee-for-service care), modifications to the benefits package (such as $1,000 annual cap on dental services for adults), and beneficiary cost sharing.

## B. AGENCY CAPACITY

The programs of the MCAH/OFP and CMS Branches have been developed to address the three core public health functions: needs assessment; development of program policies to address needs and improve health outcomes; and assurance of the availability of accessible and appropriate high-quality services. Assuring cultural competence and access to services in a community-based setting are both important principles of DHS policy development.

The programs of the MCAH/OFP and CMS Branches include the following:
Adolescent Family Life Program (AFLP)
Adolescent Sibling Pregnancy Prevention Program (ASPPP)
AFLP/ASPPP Management Information System
Adolescent Health Program
Advanced Practice Nursing Program
Battered Women's Shelter Program (BWSP)
Black Infant Health (BIH)
BIH Management Information System
California Children's Services (CCS)
California Diabetes and Pregnancy Program (CDAPP)
California Perinatal Transport Centers
Child Health and Disability Prevention Program (CHDP)
Childhood Injury Prevention Program (CIPP)
Comprehensive Perinatal Services Program (CPSP)
Comprehensive Perinatal Services Training
Family Health Outcomes Project (FHOP) and Local MCAH Data
Family Planning Access Care and Treatment (Family PACT)
Fetal Infant Mortality Review Program (FIMR)
Genetically Handicapped Persons Program (GHPP)
Health Care Program for Children in Foster Care (HCPCFC)
Maternal Child and Adolescent Health Program (MCAH)

MCAH in Schools (formerly named School Health Connections)
Medical Therapy Program (MTP)
Medically Vulnerable Infant Program (MVIP)
Newborn Hearing Screening Program (NHSP)
Oral Health
Perinatal Profiles and Improved Perinatal Outcomes Data Reports Website
Regional Perinatal Programs of California (RPPC)
Sudden Infant Death Syndrome (SIDS) Program
Teen Pregnancy Prevention Programs
Youth Pilot Program (YPP) and Integrated Health and Human Services Pilot

Preventive and Primary Care Services for Pregnant Women, Mothers and Infants

> Support to local infrastructure

Several systemwide programs, including MCAH, CCS, and CHDP, are administered by local health departments under the direction and guidance of the MCAH/OFP and CMS Branches. In addition to setting statewide policy, the State funds local health departments for these activities.

The Youth Pilot Program (YPP) funds six counties to implement programs which provide integrated, comprehensive services for children and their families. YPP focuses on high-risk, multi-need, low-income youth and their families. The YPP pilots allow counties to make decisions locally regarding the best use of state and local human services funds without a reduction of state and federal funds. YPP was established in 1995 and has been reauthorized through January 2009.

> Quality of maternity services

The California Perinatal Quality Care Collaborative (CPQCC) is a cooperative effort of public and private obstetric and neonatal providers, insurers, public health professionals (including MCAH/OFP and CMS), and business groups. It is working to develop an effective perinatal and neonatal quality improvement infrastructure at state, regional, and hospital levels. CPQCC membership has grown to over 100 hospitals and accounts for most newborns requiring critical care in California. Participating hospitals receive an annual online report with comparative analysis on perinatal and neonatal data.

The Perinatal Quality Improvement Panel (PQIP), a subcommittee of CPQCC, recommends quality improvement objectives, provides models for performance improvement, and assists providers in a multi-step transformation of data into improved patient care through the use of toolkits, workshops, and follow-up. MCAH/OFP and CMS staff are members of the CPQCC Executive Committee and PQIP.

The MCAH/OFP Branch recently developed the Maternal Quality Collaborative (MQC), a joint effort with the CPQCC and UCLA's Maternal Quality Indicators group. The MQC Leadership Council includes members from CCS, MCAH/OFP, MCMC, and Medi-Cal Policy Section. The MQC will direct statewide maternal quality improvement activities utilizing the methodology developed by the CPQCC.

CDAPP works to promote optimal management of diabetes in at-risk women, before, during and after pregnancy. CDAPP has care guidelines which address everything from lab values to billing and data issues.

> Infants' access to care

Medi-Cal, Healthy Families (HF) and Access for Infants and Mothers (AIM) provide health insurance

coverage for infants. Medi-Cal reaches infants living in households with incomes below 200 percent of FPL. HF provides insurance coverage for infants in households with incomes up to 250 percent of the FPL; monthly premiums and copayments for certain types of visits and prescriptions are required. AIM provides state-subsidized third party insurance for infants in households with incomes between 200 and 300 percent of FPL.

Preventive screening and basic health services are provided to infants under a year of age by the CHDP program. In FY 2002-03, 529,755 infants under one year of age received health services through CHDP. This was a 2.6 percent increase from the prior year. Of these infants, 64 percent had Medi-Cal coverage and 36 percent were state-funded (compared with 61 percent and 39 percent in FY 2001-02). Of the 529,755 infants served in FY2002-03, 66 percent were Hispanic, 10 percent White, 5 percent African American, and 6 percent Asian. The only ethnic group with significant change in the number of infants served was the Asian ethnic group with a 31.4 percent increase in the number of infants from the prior year.

> Infant Health Promotion

Preventive screening and basic health services are provided to infants under a year of age by the CHDP program. In FY 2002-03, 529,755 infants under one year of age received health services through CHDP. This was a 2.6 percent increase from the prior year. Of these infants, 64 percent had Medi-Cal coverage and 36 percent were state-funded (compared with 61 percent and 39 percent in FY 2001-02).

DHS promotes exclusive breastfeeding initiation at birth and prolonging breastfeeding during infancy. Breastfeeding is promoted across all MCAH/OFP programs serving pregnant women and infants. Informational materials regarding breastfeeding, nutrition and immunizations for women, adolescents, children, and infants, are regularly disseminated to AFLP, BIH, CPSP, and RPPC providers. The CDAPP Guidelines for Care include a chapter on breastfeeding. The MCAH/OFP website includes a page devoted to breastfeeding. The page includes data on postpartum hospital breastfeeding discharge rates, local breastfeeding coalitions, links to other breastfeeding resources, and model breastfeeding policies. MCAH/OFP also offers technical assistance to hospitals to improve their breastfeeding policies.

Birth defects remain the number one cause of infant deaths. While the causes of many congenital defects have yet to be identified, effective measures for the prevention of a significant portion of neural tube defects are known. MCAH/OFP Branch activities focus on folic acid promotion during the preconception and prenatal periods to reduce the risk of neural tube defect-affected pregnancies. The MCAH/OFP Branch is an active participant in the National Council on Folic Acid.

The Genetic Disease Branch (GDB) of DHS provides newborn screening for primary hypothyroidism, phenylketonuria (PKU), galactosemia, sickle cell disease and other hemoglobinopathies to 99 percent of the newborn population. The Newborn Screening (NBS) Program is expanding to include over 40 additional metabolic conditions detectable via Tandem Mass Spectrometry (MS/MS), and classical congenital adrenal hyperplasia. CMS is working with the GDB to inform CCS-approved Special Care Centers (SCCs) and CCS County and Regional Offices of the expansion and to enlist their help in expediting referrals for infants with positive screening test results. The CCS program is authorizing the appropriate SCC for diagnostic evaluations for all infants referred by the NBS program. This combined program effort is imperative to ensure early diagnosis to avoid serious disabilities and even death in some cases.

Several programs of the MCAH/OFP Branch address additional causes of infant mortality and morbidity. The SIDS Program has facilitated the SIDS Risk Reduction campaign, also known as Back to Sleep (BTS) in California. The rate of death due to SIDS in California declined from 94.5 per 100,000 live births in 1992 to 32.3 in 2003. In 2003 the rate of African American infant deaths from SIDS was more than twice that of any other group: 99.3 per 100,000 for African Americans, 35.5 for

Whites, and 25.6 for Hispanics.

The Black Infant Health (BIH) Program has the goal of reducing African-American infant mortality in California. BIH funds programs in 17 counties, and these counties account for 94 percent of the state's African American births.

California's Fetal Infant Mortality Review (FIMR) Program, which took a significant budget cut in FY 2002-03, was expanded this year, with a $250,000 reallocation of Title V funds. This new funding has established the Black Infant Health FIMR (BIH/FIMR) Program. The goal of the BIH/FIMR program is to reduce African American fetal and infant deaths through review of these deaths at the community level. Eight of the seventeen FIMR jurisdictions with the greatest proportion of African American births have been selected for participation.

The MCAH/OFP Branch prepared a grant application to CDC for a Fetal Alcohol Syndrome Program, but it was not funded. MCAH/OFP continues to network with counties that are addressing Fetal Alcohol Spectrum Disorder (FASD).

There are 176 hospitals certified and participating in the Newborn Hearing Screening Program as of March 2005, up from 159 one year ago. During CY 2004, over 370,000 infants received hearing screening prior to hospital discharge, and 523 infants were identified with hearing loss, an incidence rate of 1.4 per 1000. Among NICU infants, the incidence of hearing loss was 5.5 per 1000. Only 6 percent of infants who needed additional evaluation after hospital discharge were lost to follow-up (compared to 30-50 percent in other states).

Preventive and Primary Care for Children

> Access to care

Medi-Cal and HF provide access to a comprehensive package of primary and preventive services, including dental care, for California's low-income children. Medi-Cal covers children ages 1 through 5 up to 133 percent of FPL, children and adolescents ages 6 up to 19 at up to 100 percent of FPL, and young adults ages 19 to 21 at up to 86-92 percent of FPL. HF covers children from 0 through 18 years of age who are uninsured and living in households with incomes up to 250 percent of FPL. Monthly premiums and copayments for certain types of visits and prescriptions are required. There were 697,305 children enrolled in HF as of December 2004. This is a 2 percent increase from December 2003 and a 24 percent increase from March 2002.

The CMS Branch administers the screening component of the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) entitled the CHDP program. CHDP provides preventive services, including health assessments, immunizations, screening tests, dental screening, anticipatory guidance, health education, and referral for further diagnosis and treatment for Medi-Cal-funded children up to 21 years of age. Uninsured children and youth up to 19 years of age in families with incomes at or below 200 percent of the FPL are eligible to pre-enroll in Medi-Cal through the Gateway process.

In FY 2002-03, 2,114,480 children received screening and health assessments through the CHDP program, a 1.3 percent increase from FY 2001-02. There was a continued increase in the number of children receiving services enrolled in MCMC plans through which they receive health assessments. Of the over 2.1 million children receiving CHDP services, 60 percent were funded by Medi-Cal and 40 percent were funded through state funds, representing a 9 percent increase in Medi-Cal funded services. Of the Medi-Cal recipients, 30 percent received services through fee-for-service Medi-Cal and 70 percent through the MCMC plans.

The CHDP Gateway, implemented in July 2003, has pre-enrolled 1.2 million children through February 2005, and 80 percent of them have requested a joint Medi-Cal/HF application. DHS has

modified the pre-enrollment process that allows the Gateway transaction to identify and "deem" certain infants less than one year of age as eligible for ongoing, full-scope, no cost Medi-Cal at the time of a CHDP health assessment. The families of these infants do not have to complete a Medi-Cal application. Through this process, 42,837 infants were enrolled in Medi-Cal through February 2005.

> Childhood/adolescent health promotion

Injuries are the leading cause of mortality among children and youth. To reduce injury-related mortality and morbidity among children and adolescents, MCAH/OFP contracts with the Center for Injury Prevention Policy and Practice (CIPPP) at San Diego State University (SDSU). CIPPP provides technical assistance and training for local MCAH programs through conferences, a list serve, and weekly literature reviews of the latest injury prevention research. The MCAH/OFP Branch continues to fund five local MCAH jurisdictions to increase injury prevention capacity within their community.

As a part of the California Initiative to Improve Adolescent Health by the Year 2010, the National Adolescent Health Information Center (NAHIC) and the California Adolescent Health Collaborative (AHC) continue to provide support to local jurisdictions interested in adolescent health. During last fiscal year, the Guide to Adolescent Health Data Sources was produced to assist locals who were interested in adolescent health to better assess the needs of the youth in their community. NAHIC and AHC provide technical assistance to assist local programs in developing a grant application template that they can use for future applications to foundations and federal agencies. The California AHC also puts out an annual report card on key adolescent health indicators.

The MCAH/OFP Branch applied for a System Capacity for Adolescent Health Technical Assistance Grant from the Association of Maternal and Child Health Programs (AMCHP), but did not receive one. In spite of this, California hopes to continue to assess and improve adolescent health system capacity in the State.

The MCAH/OFP Branch held an Adolescent Health System Capacity Assessment stakeholder meeting in April 2005, in addition to local feedback meetings with MCAH Directors, AFLP regional representatives, and TPP grantees. Preliminary results of these meetings reveal that there is a great need to increase efforts in general adolescent health at the MCAH/OFP Branch and increase partnerships especially in the areas of mental health, education, substance abuse, and juvenile justice. In addition, the local jurisdictions want to see more state staff attending local events and visiting programs so that stronger partnerships between state and local programs can be fostered. Local jurisdictions also expressed a strong need for more financial and human resources for adolescent health so that they could implement California's adolescent health strategic plan at the local level.

Participants in the adolescent health system capacity assessment meetings noted that the Branch had good data and programs addressing teen pregnancy prevention, but information and programs in other areas needed to be expanded, including standardized youth development measures. In general, participants expressed a desire to have a more comprehensive, integrated, dedicated focus on adolescent health at the MCAH/OFP Branch. MCAH/OFP staff will use the information from these meetings to plan ways to better serve our local constituents in the coming years.

The MCAH/OFP Branch participates in the multi-agency California Coalition for Youth Development. The coalition serves to improve youth development throughout California through the annual Youth Development Summit and other projects. Participants include the Attorney General's Office, CDE, 4-H Center for Youth Development, Friday Night Live, Alcohol and Drug Program, and the Department of Mental Health (DMH).

The MCAH/OFP Branch received a two-year planning grant for 2003-2005 from HRSA for the State Early Childhood Comprehensive Systems (SECCS) Project. The goal is to provide state-level leadership for early childhood health programs to help California's children be emotionally, socially,

and physically ready for kindergarten. The project coordinates various health-related programs of state and local government with organizations such as the AAP, March of Dimes, Easter Seals, and representatives of faith-based organizations. A needs assessment and strategic plan will address and coordinate critical components of early childhood health care systems, including access to medical homes, mental health, childcare education, parent education, family support, and safety in out-of-home care. The statewide strategic plan will be finalized by October 2006.

The MCAH/OFP Branch participates in UCSF's Childcare Health Program Advisory Committee. This organization is dedicated to enhancing the quality of childcare for California's children by initiating and strengthening linkages between health, safety, and child care communities and the families they serve. This program previously received the Healthy Child Care America (HCCA) Grant, which has now been folded into the SECCS grant. UCSF's HCCA director serves as the co-director for the SECCS grant.

The CMS Branch continues to participate in the Childhood Asthma Initiative through the CAI CHDP project, consisting of asthma education, trainings, resource development, and implementation of Asthma Assessment Guidelines for CHDP providers. Through this project, which ends in June 2005, some local CHDP programs have established or become active in local asthma coalitions, and other programs have expanded their asthma community outreach.

The MCAH/OFP and CMS Branches continue to participate in the California Interagency Asthma Interest Workgroup, a collaborative that includes DHS, CDE, First Five California, and the California Environmental Protection Agency. This group serves as a forum for collaboration in addressing asthma in California.

> Services for Children with Special Health Care Needs (CSHCN)

The CMS Branch administers the CCS program that provides case management and payment of services for CSHCN. The program authorizes medical and dental services related to the CCS eligible condition. Additionally, it establishes standards for providers, hospitals, and Special Care Centers (SCC) for the delivery of care in tertiary medical settings and in local communities, and provides physical and occupational therapy and medical case conference services at selected public school sites for children with specific medically eligible conditions.

The CCS Medical Therapy Program (MTP) provides physical and occupational therapy services to children with CCS MTP eligible conditions. There is no financial eligibility requirement. The number of clients enrolled in the MTP has remained fairly stable for the past three years and is currently 26,841.

The estimated caseload for CCS in Federal Fiscal Year (FFY) 2003-2004 was 172,510. This is essentially unchanged from the prior year of 172,340. Approximately 78 percent of these children were enrolled in Medi-Cal and 10 percent in HF. CHDP providers continue to facilitate referrals to CCS of children with CCS eligible or potentially CCS eligible conditions.

The CCS program is responsible for case managing the care of the CCS eligible condition for Medi-Cal beneficiaries and authorizes Medi-Cal reimbursement for services related to the CCS condition, including EPSDT supplemental services. CCS case manages and authorizes payment of services related to the CCS eligible condition for children enrolled in HF. Through a system of CCS-approved SCCs, CCS provides access to quality specialty and subspecialty providers for CSHCN. The SCCs are located in the outpatient departments of tertiary care hospitals and use multidisciplinary teams to address health needs and provide coordinated care for CCS beneficiaries.

Thirty-one "independent" counties fully administer their own CCS programs, and 27 "dependent" counties share the administrative and case management activities with CMS Branch Regional Offices. The Case Management Improvement Project has encouraged dependent counties to assume case management functions historically done by state Regional Office staff.

The CCS Program has structured a system of regional affiliation among the 121 CCS-approved neonatal intensive care units (NICUs) to assure that infants have access to appropriate specialty consultation and intensive care services throughout the state. CCS-approved NICUs are designated as Intermediate, Community, and Regional NICUs. NICUs that provide basic level intensive care services to infants in their communities are required to have established affiliations with NICUs that provide more extensive services, to facilitate consultation and patient transfers as needed. The CCS approval process denotes the level of patient care provided in each NICU and verifies that the cooperative agreements are in place. In June 2001 the CPQCC initiated annual NICU data reporting to CCS. Annual NICU reporting is required for continuing CCS approval and reporting through the CPQCC facilitates data submission and analysis and improves reporting accuracy. The CMS Branch is requiring all CCS-approved hospitals to submit CCS NICU annual data through CPQCC beginning with CY 2004 data.

The CMS Branch has two programs that address the needs of high-risk infants. The first allows infants that are discharged from CCS-approved NICUs to be followed in NICU High Risk Infant Follow-up clinics. Three multidisciplinary outpatient visits are authorized by CCS during the first three years of life to identify problems, institute referrals, and monitor outcomes. Visits include a comprehensive history and physical examination, developmental testing, and ophthalmologic, audiologic, and family psychosocial evaluations.

The second program, the Medically Vulnerable Infant Program (MVIP), has used a network of community-based contractors to provide home-based services to high-risk infants from NICUs and their families. Services have been provided to infants up to three years of age. Twelve contractors, including hospitals, community-based organizations and universities, have contracts until December 2005. As of March 2005, 4,282 infants have been enrolled in the program and 51,280 home visits have been made since program inception July 2000.

The Genetically Handicapped Persons Program (GHPP) provides case management and funding for medically necessary services for people with certain genetic conditions. Most GHPP clients served in this program are adults, but 10 percent are children under 21 years. The GHPP serves eligible children with higher family incomes that make them ineligible for the CCS program. There are currently 1,563 clients enrolled in GHPP. The decline from 1,690 clients last year is primarily due to closing inactive cases. Hemophilia is the most common GHPP diagnosis followed by cystic fibrosis, sickle cell disease, Huntington's Disease, and Friedreich's Ataxia.

> Rehabilitation services to Supplemental Security Income (SSI) beneficiaries under the age of 16

SSI beneficiaries with a CCS medically-eligible diagnosis are served by the CCS program. During FY 2003-04, CCS received 2,057 referrals of SSI beneficiaries, and 52 percent of these were medically eligible for the CCS program. If physical and/or occupational therapy are needed, they can be provided in the CCS MTP. Children receiving SSI who have mental or developmental conditions are served by DMH, Department of Developmental Services (DDS), and CDE.

> Family-centered, community-based coordinated care for CSHCN

SCCs and hospitals that treat CSHCN and wish to become CCS-approved must meet specific criteria for approval. One of the criteria used in evaluation involves provision of family-centered care (FCC). During the facility review, FCC is assessed and, as part of the review, the CMS Branch sends a follow-up report to the facility with FCC recommendations.

The CCS program facilitates FCC services for families of CSHCN. CCS staffing standards allow a parent liaison position in each county CCS program to enable FCC. County programs assist families in accessing authorized services. Many families live long distances from the site of appropriate

pediatric specialty and subspecialty care. The program provides reimbursement for travel expenses (gas, bus tickets, taxis), meals for extended stays, and motel rooms for families when there are extended hospital stays.

The Children's Regional Integrated Service Systems (CRISS) (a collaboration of family support organizations, pediatric providers, statewide organizations, 14 county CCS programs in Northern California, and Family Voices of California) has a FCC Work Group that meets bimonthly. This group plans, develops and sponsors an annual fall conference (in addition to assisting with other conferences, workshops, resource fairs, and addressing issues regarding FCC); the conference for 2004 was about sexuality and youth with disabilities. CCS staff, family support agency staff and parent leaders attended, as well as staff from Regional Centers and Special Education.

The CMS Branch is directing a Champions for Progress Center Incentive Award for CY 2005 to further the development and implementation of a community-based system of care for CSHCN and their families. This project will convene a group of key stakeholders, with past investments in and knowledge of the system of care for CSHCN and their families to meet bimonthly for twelve months to develop strategies and an action plan to address the CSHCN Title V performance measures and prioritized issues resulting from the Title V Needs Assessment process. The project will build on existing coalitions and projects as well as past efforts to develop a long-term, strategic plan for serving CSHCN; it will identify resources within California to carry out the activities defined in the strategic plan.

A federal Maternal and Child Health Bureau (MCHB) grant has been awarded to the University Affiliated Program at University of Southern California / Children's Hospital Los Angeles (CHLA), collaborating with CRISS and Family Voices of California, for a 3-year project to implement integrated community systems of care for CSHCN. Activities to promote systems of care for CSHCN will be expanded in the 14 CCS County region (involved with CRISS) and in Los Angeles County, and state-focused activities will be launched. Goals for CSHCN are: to develop/implement community based family centered systems of care; promote FCC through family/professional partnerships; promote comprehensive health care through identified medical homes; promote effective transition to adult health care, work and independence; and ensure sustainability of systems of care post-project.

CCS is collaborating with CHLA and the CA Epilepsy Foundation on a grant from HRSA for Improving Access to Care for Children and Youth with Epilepsy. The overall goal of the project is to improve access to health and other services and to facilitate the development of state-wide community-based interagency models of comprehensive, family-centered, culturally-effective care and state-wide standards of care.

LA County CCS produced a "Handbook for Los Angeles County CCS Families" in English and Spanish after working for two years with low-income, English and Spanish-speaking parents; 13 Family Resource Centers; TASK (Team of Advocates for Kids); providers; Regional Centers; and LA CMS staff. The booklets will be distributed to all CCS enrolled families in early June, and new enrollees will receive a booklet with their Notice of Privacy Form.

> Transitioning services for CSHCN

The CMS Branch recognizes the importance of transitioning care for CSHCN from pediatric to adult services. Requirements for beginning transition services at age 14 will be added to the standards for the outpatient SCCs as they are revised. During site reviews of new SCCs and county CCS programs, transition issues are emphasized as important for the future delivery of medical care and services to the CSHCN.

CCS staff in Southern California regularly attend and participate with the Special Education Local Planning Areas (SELPA) Interagency Coordinating Transition Council. Some CCS County programs have transition committees. These committees receive input from CCS parents and young adult

clients to assess and develop ways to infuse the concept of transition into CCS services and functions. At the bimonthly meetings of the CRISS FCC Work Group, county CCS programs report on transition activities. A matrix of transition activities of each of the 14 counties represented is maintained and updated. The CMS Branch is contracting with CRISS to provide raw and analyzed data regarding statewide CCS program transition activities.

The CMS Branch formed a transition workgroup that has begun meeting and will ultimately develop transition policy and guidelines for the CCS program. The group includes county CCS physicians, nurses (one of whom is also a parent of a child with special needs), social workers, and therapists, as well as a physician from a MCMC plan, a community advocate, two physicians from UCLA with interest and expertise in transitional care, a representative from the Healthy and Ready to Work Program, several parents (including the Parent Liaison from LA County CCS), and a young adult who is transitioning out of CCS.

## C. ORGANIZATIONAL STRUCTURE

For updated organizational charts for the MCAH/OFP and CMS Branches, see the attachments to Sections III C and III D, respectively. The web links for organizational charts for the Primary Care and Family Health Division (PCFH) and the California Executive Branch are at http://admin.int.dhs.ca.gov/orgcharts/pdf/pcfh.pdf and http://www.cold.ca.gov/Ca_State_Gov_Orgchart.pdf, respectively.

Arnold Schwarzenegger is the Governor of California, a position he has held since November 2003. S. Kimberly Belshe is the Secretary for the Health and Human Services Agency, which is a cabinet-level position reporting directly to the Governor. Sandra L. Shewry is the Director of DHS.

The MCAH/OFP and CMS Branches have joint responsibility for carrying out the Title V functions. MCAH/OFP and CMS are located in DHS, which is in the California Health and Human Services Agency (HHSA). The MCAH/OFP and CMS Branches are in the Primary Care and Family Health (PCFH) Division of the DHS. The other Branches in PCFH are Women, Infants, and Children Supplemental Nutrition Program (WIC), Genetic Disease Branch (GDB) and Primary and Rural Health Care Systems.

The Deputy Director of PCFH is Catherine Camacho, a position she has held since February 2003. The Chief of the MCAH/OFP Branch is Susann J. Steinberg, MD, and the Acting Chief of the CMS Branch is Marian Dalsey, MD, MPH.

DHS is designated to administer the MCAH program by the California Health and Safety Code Div. 106, Part 2, Chapter 1, Article 1 Sections beginning with 123225. The CCS program is authorized by the Health and Safety Code Division 106, Part 2, Chapter 3, Article 5, Sections 123800-123995. The Genetically Handicapped Persons Program (GHPP), which provides services to individuals with certain genetic conditions, is authorized by the Health and Safety Code Division 106, Part 5, Chapter 2, Article 1, Sections 125125-125180. The CHDP program, California's preventive healthcare program for children, is authorized by the Health and Safety Code Division 106, Part 2, Chapter 3, Article 6, Sections 124025-124110 and by Division 103, Part 3, Chapter 1, Article 1, Section 104395.

Information about the MCAH/OFP Branch is provided below. Information about the CMS Branch is included in Section III D.

Maternal Child and Adolescent Health / Office of Family Planning Branch (MCAH/OFP)

In March 2005 the MCAH Branch was formally merged with the Office of Family Planning Branch to form the MCAH/OFP Branch. Prior to 2004, the MCAH Branch was known as the Maternal and Child Health Branch, or MCH.

Susann Steinberg, MD is Chief of the MCAH/OFP Branch, a position she has held since the two branches merged in March 2005. Prior to that, she had been Chief of the MCAH Branch since December 2002 and Acting Chief of the Office of Family Planning since May 2004. Dr. Steinberg is Board Certified in Family Practice as well as Preventive Medicine and has an MBA.

Laurie Weaver is the Chief of the Office of Family Planning, a position she has held since May of 2005. Prior to coming to MCAH/OFP, Ms. Weaver was employed with the California Department of Corrections, Health Care Services Division, for the last seven years.

Les Newman is the Assistant Chief of the MCAH/OFP Branch, a position he has held since the two branches merged in March 2005. Prior to that, he had been Assistant Chief of the MCAH Branch since February 2001. He has over twenty years working in leadership positions in California government and was previously Operation Section Chief within the MCAH/OFP Branch.

The MCAH/OFP Branch staff includes senior consultants in a variety of clinical, public health, and scientific disciplines. Emeterio Gonzalez, MD is a Board Certified Obstetrician and Gynecologist who serves as a medical consultant to the Branch. Eileen Yamada, MD, MPH is a board-certified Pediatrician and serves as the MCAH/OFP Pediatric Consultant, Coordinator for the Childhood Injury Prevention Program, and the State Adolescent Health Coordinator. Dr. Yamada also has responsibility for projects related to Fetal Alcohol Spectrum Disorder and Fetal Infant Mortality Review. John Mikanda, MD, MPH assists in the evaluation of the Family PACT Program.

Lori Llewelyn, MPP is Title V Principal Author, a position she has held since February 2004. Mike Curtis, PhD and Eugene Takahashi, PhD oversee the compilation of state statistics for the Title V report. Gretchen Caspary, PhD, MBA, who joined MCAH/OFP in March 2003, is the Coordinator for the Title V Five-Year Needs Assessment. This Title V team works under the direction of Shabbir Ahmad, DVM, MS, PhD, Chief of the Epidemiology and Evaluation Section of MCAH/OFP.

The MCAH/OFP Branch is divided into six sections: Programs and Policy, Epidemiology and Evaluation, Operations, Administration, Clinical Services and Quality Improvement Utilization Management, and Teen Pregnancy Prevention .

> Epidemiology and Evaluation Section

The Epidemiology and Evaluation Section provides program information for monitoring MCAH/OFP program implementation, evaluating program effectiveness, and policy development. Program and population-based data are analyzed to support California's application for Federal Title V Grant Funds and Needs Assessment. The Section also provides assessment and surveillance information for use in program related research, program policy planning, and allocation of resources. The section is organized into two research units comprised of 21 research and support staff.

Shabbir Ahmad, DVM, MS, PhD, is Chief of the Epidemiology and Evaluation Section, a position he has held since May 2003.

The Epidemiology and Evaluation Section consists of two units: Surveillance and Program Evaluation; and Epidemiology. The Chief of the Surveillance and Program Evaluation Unit is Mike Curtis, PhD. The Chief of the Epidemiology Unit is Eugene Takahashi, PhD.

The MCAH/OFP Branch has been given the additional responsibility of implementing legislation mandating the monitoring of stem cell research in California. The Branch will provide support to the Human Stem Cell Research Advisory Committee, which will advise DHS on the development of minimum standards for Institutional Review Boards to use in reviewing human embryonic stem cell research projects.

> Operations Section

The Operations Section assumes the contract monitoring functions for the Branch, including fiscal forecasting, budget related work, management of over 400 contracts, auditing functions, and working with Department of Finance and other control agencies.

Nancy Smith has been the Chief of the Operations Section since 2001.

The Operations Section has three units: the Contract Management and Policy Unit (9 staff), the OFP Contracts and Grants Unit (7 staff), and the MCAH Contracts and Grants Unit (8 staff).

> Programs and Policy Section

The Programs and Policy Section of MCAH/OFP coordinates the implementation of standards of care for pregnant women, children, and infants in the AFLP, APN, ASPPP, BIH, BIH/FIMR, CPSP, FIMR, CDAPP, CPeTS, and SIDS Programs. Program consultants develop standards and provide consultation and technical assistance to local MCAH jurisdictions and other organizations.

Anita Mitchell, MD is the new Chief of the Programs and Policy Section, effective July 2005. Dr. Mitchell is board certified in Pediatrics. Before coming to MCAH/OFP, she was the Chief Medical Officer, Medical and Public Health Programs, at the California Department of Corrections.

The Programs and Policy Section consists of four program units: two Perinatal Health Units, the Statewide Specialized Services and Programs Unit, and the MCAH in Schools Program.

The Perinatal Health Units are supervised by Nurse Consultant Supervisors Joyce Weston, BS (Nursing), MS (Healthcare Services Administration) and Leona Shields, MN, CNP. These two units consist of a staff of nine. The Perinatal Health Units provide technical assistance and consultation to 61 health jurisdictions regarding their MCAH Scope of Work and Allocation, AFLP/ASPPP, Breastfeeding Support Programs, FIMR programs, and BIH/FIMR. They also provide technical assistance and consultation to the 43 AFLP/ASPPP agencies.

The Statewide Specialized Services and Programs Unit has overall responsibility for the BIH and SIDS programs and the perinatal quality improvement contracts with the RPPC, CDAPP, CPeTS, APN and CPSP. The unit is also responsible for technical assistance and consultation to eighteen community-based organizations that provide AFLP services, eight of which also provide ASPPP services. The unit consists of five staff positions.

The MCAH in Schools Program (formerly called School Health Connections) is under the leadership of Ellen Buchanan, Health Program Specialist II. The number of staff is down from eight in 2002 to one in 2005. The focus of MCAH in Schools is to foster collaborative linkages between local MCAH staff and school nurses, teachers and/or principals to promote best practices through combining health education, health promotion and disease prevention, and access to health-related services in an integrated and systematic manner.

> Administration Section

The newly created Administration Section is responsible for the accounting functions, program evaluation and planning, policy analysis and formulation, analytical studies, activities associated with provider enrollment and program integrity, and coordination of Title V activities within the Programs and Policy Section.

The Administration Unit consists of the Accounting and Business Operations Unit (7 staff), Special Projects and Administrative Support (8 staff) and Office Support Unit (7 staff). Linda LaCoursiere is

Chief of the Administration Section.

> Clinical Services and Quality Improvement Utilization Management Section

The Clinical Services and Quality Improvement Utilization Management Section consists of the Clinical Services Unit (7 staff) and is responsible for the overall implementation and evaluation of the Family Planning Access Care and Treatment Medicaid Waiver Demonstration Project.

Amy Krawiec, MD is the Chief of the Clinical Services and Quality Improvement Utilization Management Section, a position she has held since March 2005. Dr. Krawiec is board certified in Family Practice, has worked in clinical medicine for six years and has worked as a medical consultant with DHS Audits and Investigations prior to coming to MCAH/OFP.

> Teen Pregnancy Prevention Section

The Teen Pregnancy Prevention Section (8 staff) consists of four grant programs (Community Challenge Grant, Information & Education, Male Involvement, and Teen Smart) to reduce the incidence of teen pregnancies. The program serves approximately 460,000 teens and parent participants through nearly 200 grants and contracts annually. Martha Torres-Montoya, MSPH, is the Section Chief; she has over twenty-five years experience in family planning, teen pregnancy prevention, and multilingual/multicultural health education programs.

> Domestic Violence (DV) Program

For the DV program, FY 05/06 marks the beginning of the first year of a five-year grant cycle and consolidation of the shelter, prevention and unserved/underserved (UU) grants. Under the guidance of the Agency Secretary, MCAH/OFP is providing all 94 shelters with Shelter, Prevention and U/U funding. The two technical assistance training support contracts will continue. The unit consists of seven staff positions and is managed by Carolynn Michaels, MBA.

## D. OTHER MCH CAPACITY

Information about the MCAH/OFP Branch is provided in Section III C (Organizational Structure) above. Information about the CMS Branch is provided below.

Children's Medical Services (CMS) Branch

Marian Dalsey, MD, MPH is the Acting Branch Chief, a position she has held since April 2004. Dr. Dalsey is a board certified pediatrician. She has held positions in healthcare administration and policy development at the local level in California and Illinois and with Medi-Cal and CMS at DHS. Harvey Fry is the Assistant Branch Chief, a position he has held since January 2005.

The CMS Branch has been undergoing reorganization in 2005. The Branch is now composed of the following five sections: Program Development, Regional Operations, Statewide Programs, Program Support, and Information Technology.

> Program Development Section (PDS)

PDS is responsible for the development and implementation of program policy, regulations, and

procedures for the programs administered by the Branch and for provision of statewide consultation in a variety of professional health disciplines. The section consists of two units: the Program Policy and Analysis Unit and the State Consultation Unit.

The Program Policy and Analysis Unit is responsible for development and implementation of program policy, regulations, and procedures for all programs administered by the Branch. Unit staff develop provider standards for CCS; develop policies and procedures to assist in the implementation of Medi-Cal Managed Care and the Healthy Families program; review and approve/deny all requests for organ transplants for children covered by CCS and Medi-Cal; and provide pediatric consultation to Medi-Cal and other DHS programs. The unit is also responsible for research and program analysis functions and development and implementation of a pharmaceutical rebate program for CCS and GHPP.

The Statewide Consultation Unit staff provide expertise in the disciplines of medicine, nursing, social work, nutrition, dentistry, dental hygiene, health education, and physical therapy and participate in the evaluation and monitoring of county CCS and local CHDP programs for compliance with federal and state regulations and local policies and procedures. Staff in the unit are also responsible for ensuring that all providers who deliver services to children are qualified and in good standing with the appropriate board under the Department of Consumer Affairs and for assisting with on-site reviews of hospitals, special care centers, neonatal and pediatric intensive care units, and medical therapy units for compliance with established program standards, policies, and procedures.

Marian Dalsey, M.D., M.P.H., board certified pediatrician and Acting Branch Chief, is also Acting Chief of this section, a position she has held since 2002. PDS has 19 positions.

> Regional Operations Section (ROS)

ROS is composed of three CMS regional offices located in Sacramento, San Francisco, and Los Angeles. The section provides case management services for CCS-eligible clients residing in dependent counties (those with populations of less than 200,000). Case management services include, but are not limited to, determination of medical eligibility and authorizations for services, resolution of financial appeals, determination of eligibility for Medical Therapy Unit services, and program consultation/technical assistance. The ROS consultant staff are responsible for review and approval of Early and Periodic Screening, Diagnosis, and Treatment Supplemental Services requests statewide.

Regional office professional staff also have oversight responsibilities for local CCS and CHDP programs, including evaluating and monitoring county CCS and local CHDP programs for compliance with federal and State regulations and local policies and procedures. Oversight responsibilities include, but are not limited to, program development, review and approval of annual budgets and workplans, and provision of technical assistance and program consultation.

Staff in the regional offices are responsible for coordinating and facilitating on-site reviews of hospitals, special care centers, neonatal and pediatric intensive care units, and medical therapy units for compliance with established program standards, policies, and procedures and for certifying outpatient rehabilitation centers located within CCS medical therapy units.

Maurice Robertson is the ROS Section Chief, a position he has held since March 2005. He has held management positions in both health care and social services programs at the county and state level over his 29 years of government service; during the last 5 years he has served as a manager with WIC and Assistant Branch Chief of CDC Laboratories in Richmond. ROS has 50 positions.

> Statewide Programs Section (SPS)

The Statewide Programs Section is responsible for administration of specialty programs with

statewide responsibilities. There are three units within the section: Specialty Programs, Hearing and Audiology Services, and the Genetically Handicapped Persons Program (GHPP).

The Specialty Programs Unit is responsible for implementation and monitoring of specialty programs under the purview of the CMS Branch such as the Childhood Asthma Program, Health Care Program for Children in Foster Care, and Medically Vulnerable Infants Program. Staff in the unit are responsible for collaboration efforts with local programs in implementation activities and for ensuring that providers, hospitals, Special Care Centers, other State programs, local agencies, community-based organizations, and the general public are informed and assisted in the process of providing services to eligible populations.

The Hearing and Audiology Services Unit is responsible for implementation and monitoring of the Newborn Hearing Screening Program (NHSP) and for providing consultation/technical assistance to providers and local programs regarding program benefits. Staff in the unit monitor contracts with NHSP Hearing Coordination Centers providing follow-up testing and treatment services to infants with suspected hearing loss; evaluate and certify school audiometrists; and train CHDP providers to perform hearing testing in schools.

GHPP provides all medical and administrative case management services for approximately 1800 clients statewide with serious, often life threatening, genetic conditions (e.g., hemophilia, cystic fibrosis, sickle cell anemia).

Joleen Heider is the Section Chief of SPS as of May 2005. She has a BS in Dietetics and is a registered dietitian. She has been in state service for ten years, with her last position as a HPM II with the MCAH Branch overseeing the Domestic Violence Program. She has worked in other DHS programs including the Office of AIDS and WIC, and has been employed by the Department of Corrections, Health Care Services Division. SPS has 30 positions.

> Program Support Section (PSS)

PSS is composed of three units and has responsibility for a variety of activities in support of Branch operations. The Administration Unit is responsible for fiscal, personnel, contracting, purchasing, and business services for the Branch. Staff in the unit review, approve, and monitor CCS county programs and CHDP county/city budgets; resolve county budgeting/invoicing issues; develop and implement administrative and fiscal procedures for new programs administered by the Branch; develop and manage contracts and interagency agreements; process contract and county expenditure invoices; and maintain personnel and business services transactions for all CMS Branch staff. Unit staff also develop and participate in training programs for State and county program staff relating to the above areas of responsibility.

The Provider Services Unit is responsible for enrolling providers for the CCS, CHDP, and GHPP programs and acts as a liaison between CMS Branch programs, their providers, the Medi-Cal Payment Systems Division, and the State fiscal intermediary, Electronic Data Systems (EDS). The PSU works with individual providers, hospitals, and CCS/GHPP Special Care Centers to resolve provider reimbursement issues.

The Clerical Support Unit provides general clerical support services to CMS Branch management and staff. The unit is responsible for completion of complex typing assignments, formatting of proposals, regulations, program standards, reports, research papers, etc. The Clerical Unit also assists in organizing and filing all program documents; responds to telephone calls, faxes, and e-mails; disseminates program information to State staff, local agencies, the general public, and various other organizations; coordinates meetings; and makes travel arrangements for Branch staff.

The Section Chief of PSS is Erin M. Whitsell. She has held this position since 2003. There are currently 28 positions in this Section.

> Information Technology Section (ITS)

ITS is responsible for all aspects of information technology support for the CMS Branch and CMS Net, the Branch's automated case management system. This includes CMS Branch office products, CMS Net network support, CMS Net operations, and CMS Net Help Desk operation. The section provides consultation to the State Health and Human Services Agency Data Center regarding county LAN/WAN connectivity and is responsible for corrections and modifications to CMS Net application.

The section is divided into two units: Information Systems and Information Technology. There are 11 state staff, two student assistants, and 12 contract staff. William White has been the Section Chief since 2003.

## E. STATE AGENCY COORDINATION

The lead on Title V programs in California is taken by the MCAH/OFP and CMS Branches of the PCFH Division of the DHS. The MCAH/OFP and CMS Branches coordinate with several other departments and offices, both within and outside of DHS, on programs related to Title V. In addition, MCAH/OFP and CMS Branches work with various universities and professional organizations on programs and projects related to Title V.

Inter- and intra-agency collaboration is vital for meeting the needs of all children and particularly CSHCN. MCAH/OFP and CMS have numerous collaborative relationships with state and local public health agencies, in both the public and private sectors, as well as working relationships with organizations such as local foundations, medical professional associations, coalitions and children's advocacy groups.

CPQCC is a cooperative effort of public and private obstetric and neonatal providers, insurers, public health professionals (including MCAH/OFP, CMS, and other branches of DHS), and business groups. It is working to develop an effective perinatal and neonatal quality improvement infrastructure at state, regional, and hospital levels.

The MCAH Branch has received a two-year planning grant for 2003-2005 from HRSA for the SECCS project, which focuses on interagency collaboration and coordination. The goal is to provide state-level leadership for early childhood health programs to help California's children be emotionally, socially, and physically healthy and ready for kindergarten. The project will coordinate a myriad of health-related programs at the state and local levels, including: DHS, Department of Mental Health (DMH), Department of Social Services (DSS), Department of Education (CDE), Department of Developmental Services (DDS), First Five California, Managed Risk Medical Insurance Board (MRMIB); organizations such as the American Academy of Pediatrics, Family Voices of California, March of Dimes, Easter Seals, Interagency Coordinating Council for Children with Disabilities; and representatives of faith-based organizations (e.g. California Council of Churches). Parent involvement is also a critical component of the planning and implementation process for the SECCS project.

The State Interagency Team (SIT) is a high-level collaborative effort to provide better coordination of services and strategies for children and families in California. The State agencies represented on the SIT (at the deputy director level) include DSS, DHS, DMH, CDE, DDS, the Department of Alcohol and Drug Programs, and the Department of Employment Development, as well as the Attorney General's Office, the California Children and Families Commission, and the California Workforce Investment Board. The Team promotes the alignment of planning, funding and policy development across state agencies to build community capacity, maximize funding, remove regulatory barriers, ensure accountability, promote strength-based practices, and share information and data. The CMS Branch was participating on SIT, but since April 2004, the MCAH Branch is representing DHS on SIT.

Department of Education (CDE)

The MCAH/OFP Branch collaborates with CDE on the SECCS grant initiative to ensure a coordinated approach to early childhood health programs to help California's children be healthy and ready for school.

The MCAH/OFP Branch works closely with CDE and the Sexually Transmitted Disease (STD) Control Branch in improving the sexual health of youth in California. A larger stakeholder group including members of the Office of AIDS, DSS, and other DHS programs are also participating to determine important cross-cutting issues for future and continued collaboration.

The CMS Branch is working with CDE (1) to assure that all infants with hearing loss identified through the NHSP are referred to Early Start and (2) in partnership on the Maternal and Child Health Bureau grant for improving services for early identification and intervention of hearing loss.

The CCS Medical Therapy Program is working with CDE on interagency coordination. One example is working together on the structuring of the school-based Medical Therapy Unit, both for new construction and remodeling of existing Units.

Department of Developmental Services (DDS)

CCS and Medi-Cal provide medical services to eligible infants and toddlers in the Early Start Program. Through CMS participation on the Interagency Coordinating Council and Health Services Committee, CMS maintains ongoing communication with DDS.

The CMS Branch is collaborating with the MCMC Division and DDS to finalize an interagency agreement between the Early Start Program and DHS to establish a common set of working guidelines and procedures in coordinating early intervention services for children aged 0-3 years.

The MCAH Branch collaborates with the Early Start program at DDS on the planning and implementation activities of the SECCS grant. This is one of several programs essential to addressing the needs of young children with special needs.

Department of Social Service (DSS)/Children in Foster Care

The Health Care Program for Children in Foster Care (HCPCFC), implemented in 2000, is a collaboration between DSS and CMS to improve access to and oversight of health care for children and youth in foster care settings. The HCPCFC, administered locally by the CHDP program, continues to work very closely with local foster care programs to coordinate preventive and specialty health services for children and youth in out-of-home placement. The CMS Branch has initiated a performance measure to evaluate the effectiveness of HCPCFC case management. Data collection for the Performance Measure has been a challenge, but a solution is being addressed that should result in a statewide database in a few years.

The MCAH Branch collaborates with DSS Foster Care on the planning and implementation activities of the SECCS grant with regard to addressing needs of young children and their families to help facilitate prevention of out-of-home placement and to ensure that children are healthy and ready to learn.

Managed Risk Medical Insurance Board (MRMIB)

The CMS Branch and MRMIB are working cooperatively to coordinate quarterly meetings throughout the state for the medical plans. A separate meeting is coordinated with the dental plans as CCS dental and orthodontic services are carved out. Ad hoc subcommittees composed of members from CCS and MRMIB have successfully worked together on provider training and solving program issues.

DHS Environmental Health Investigations Branch (EHIB)

The Environmental Health Investigations Branch is partnering with the MCAH/OFP and WIC Branches to conduct a survey of fish consumption among pregnant women in San Joaquin County. This county borders the California Delta where there is concern about mercury contamination in the fish supply.

DHS Childhood Lead Poisoning Prevention Branch (CLPP)

The CMS Branch, through CHDP, provides lead screenings for children. The CCS program covers the cost of the evaluation and treatment of serious lead poisoning cases. Because of concerns about inadequate identification of low income children with lead poisoning, the CHDP program and CLPP have developed a new approach to lead screening that considers all low income children to be at risk and requires blood lead screening in this population.

The MCAH/OFP and CMS Branches participate in the statewide planning process led by CLPP to eliminate childhood lead poisoning in order to meet the Healthy People 2010 goal. By 2010, the goal is to eliminate blood lead levels of concern in young children. Strategic planning meetings have been ongoing and a draft plan has been circulated. The planning makes use of new information being generated by legislatively mandated universal laboratory reporting of blood lead tests results to DHS.

DHS Immunization Branch (IZ)

The CMS Branch collaborates with the IZ Branch and its Vaccines For Children (VFC) program by providing vaccinations through the CHDP program. The CMS and IZ Branches are currently collaborating on making adult tetanus diphtheria toxoids (Td) preservative free available as a VFC-CHDP vaccine, making FluMist available as a VFC-CHDP vaccine to age-appropriate siblings and household contacts of high risk children, and making Menactra™ vaccine (for prevention of Meningococcal meningitis) available to age appropriate CHDP enrolled youth as a VFC-CHDP vaccine.

DHS Sexually Transmitted Disease (STD) Control Branch

The MCAH Branch works closely with CDE and the STD Control Branch in improving the sexual health of youth in California. A larger stakeholder group including members of the Office of AIDS, Department of Social Services, and other DHS programs are also participating to determine important cross-cutting issues for future and continued collaboration.

DHS Medi-Cal Managed Care Division (MCMC)

Memoranda of Understanding (MOUs) between county health plans, CHDP and CCS are mandated by DHS. Each local program coordinates with the plans and maps out a procedure for working together. Ad hoc subcommittees composed of members from CCS and the MCMC plans have successfully worked together on provider training and solving program issues. Liaison activity continues with individual plans and with MCMC on system, policy, care coordination, and education issues.

The MCAH/OFP Branch collaborates with the MCMC Division on their project to improve the rate of preventive health care visits by adolescents. The MCAH/OFP Branch and the CMS Branch collaborate with MCMC on their Interagency Work Group for the Behavioral, Emotional, and Social Screening and Treatment for Primary Care Providers (BEST-PCP) in MCMC Project. BEST-PCP focuses first on a discrete set of policy and structural issues at the state and county levels that must be addressed to facilitate meaningful change at the practice level. The project then aims to develop and implement a model for changing provider practice as the basis for broader collaborative quality improvement efforts. The MCAH/OFP and CMS Branches are also participating in a new quality improvement project on Improving Nutrition and Physical Activity Care within MCMC.

DHS Epidemiology and Prevention for Injury Control Branch (EPIC)

The MCAH/OFP Branch collaborates with the EPIC Branch on injury prevention activities, including local training programs. The two Branches have had several meetings on areas of joint interest, including SIDS, Child Death Review Team, and review of applications for local MCAH/OFP injury prevention program funding. Other areas of collaboration include: SAFE-KIDS California Advisory Committee, the Strategic Coalition on Traffic Safety, and the Battered Women Shelter Program.

DHS Birth Defects Monitoring Program

Coordination with the California Birth Defects Monitoring Program (CBDMP) is essential in DHS's efforts to reduce birth defects. CBDMP is recognized worldwide for the quality and scope of its birth defects surveillance data and for the quality of its research to identify causes of birth defects. For example, CBDMP discovered that folic acid taken at the time of conception prevents several types of birth defects. This finding, consistent with other research results, was the basis for the federal Food and Drug Administration's decision to fortify grains with folic acid. Recently, CBDMP found that tobacco smoking during pregnancy is associated with development of cleft lip and palate. This finding has been used by First Five in their smoking cessation campaigns. The annual cost savings from the folic acid and smoking cessation strategies is estimated at $100 million. Title V funds are used to partially fund birth defects surveillance in Los Angeles, Orange, San Diego, San Francisco, and Santa Clara Counties. Additionally, Title V funds are supporting the development and on-going maintenance of the CBDMP website, which has been a fundamental tool for communicating the results of birth defects research and raising awareness about the issue of birth defects and the importance of research in identifying causes of birth defects.

DHS Office of Audits and Investigations

The MCAH/OFP Branch works closely with the DHS Audits and Investigations Division to ensure the integrity of MCAH/OFP programs.

DHS Primary Care and Family Health Division (PCFH)

In addition to the MCAH/OFP and CMS Branches, there are four other branches in the PCFH Division of DHS: GDB, OFP, Primary and Rural Health Care Systems Branch (including the Indian Health Program), and WIC. MCAH/OFP and CMS work closely with all of these offices.

Genetic Disease Branch (GDB)

CCS provides services for conditions identified on newborn screening tests and develops standards for and approves Metabolic, Endocrine, and Sickle Cell Special Care Centers (SCCs) where these

children are treated. The MCAH/OFP Branch is working with GDB on a campaign to educate women about pre-pregnancy folate use.

GDB services are provided by private providers under contract for newborn, prenatal, and Tay Sachs screenings. GDB enforces quality standards via contract requirements or by regulations; in addition to the screening program, GDB also monitors quality standards for Rh testing, genetic counseling and mandated laboratory reporting of cytogenetics. GDB also engages in research projects to develop new or improved tests.

Beginning on or before August 2005, the Newborn Screening Program of the GDB will be expanded to include newborn screening for congenital adrenal hyperplasia and other inborn errors of metabolism. The CMS Branch is working closely with the GDB through the development of policy and procedures to ensure that infants with abnormal screening results receive expeditious diagnostic evaluations and treatment services as needed in Endocrine, Metabolic, and Sickle Cell SCCs throughout the state. Pilot testing for the expanded program has begun in several geographic areas around the state.

Women, Infants & Children (WIC) Supplemental Nutrition Branch

The MCAH/OFP and CMS Branches collaborate with WIC in a variety of areas including: the improvement of prenatal care, linkages between MCAH/OFP and WIC data files, obesity prevention, oral health, childhood injury prevention, and breastfeeding.

Staff from the MCAH/OFP, CMS, and WIC Branches come together quarterly for nutrition coordination meetings. The CMS Branch ensures that the PedNSS data are available to WIC local agencies and assists WIC agencies with data interpretation.

Universities

The MCAH/OFP and CMS Branches work closely with public health and other departments of several campuses of the University of California and other universities in California. These include the National Adolescent Health Information Center and the Center for Reproductive Health Research & Policy at UC San Francisco (UCSF), Stanford University (on CPQCC issues), and the Center for Injury Prevention Policy and Practice at SDSU. The MCAH/OFP Branch contracts with the UCSF Family Health Outcomes Project (FHOP) to provide consultation and training to local MCAH/OFP jurisdictions in monitoring and updating of their local five year plan, data collection, identification of data sources, data analysis and survey development. The CMS Branch contracted this year with UCSF FHOP for consultation, data analysis, and stakeholder meetings and interviews for the Title V Needs Assessment. The MCAH/OFP Branch also collaborates with UCSF to conduct, analyze, and report on the Maternal and Infant Health Assessment Survey.

Through the Advanced Practice Nursing Program, the MCAH/OFP Branch provides funds to nine universities in California to maintain accredited advanced and midlevel nursing programs. These programs assist MCAH/OFP to meet Title V objectives by improving access to quality health care services to a diverse population through appropriately trained health care providers. Participating universities provide clinical preceptorships in medically underserved areas and provide the MCAH/OFP Branch with program evaluation data.

California District of the American Academy of Pediatrics (AAP)

The CMS Branch has collaborated with the AAP in developing guidelines for local CCS programs regarding the definition of a "medical home" and authorization of pediatricians and other primary care providers to provide these services for CSHCN. The AAP has been involved in planning and

implementing the NHSP, and has partnered with the CMS Branch in physician education and outreach for the NHSP.

Four AAP Chapter Champions for Newborn Hearing Screening participate in local and statewide forums and conferences educating hospitals, pediatricians, families, and service providers about newborn hearing screening and the need for linkage with a medical home. In 2004 CMS worked with the AAP to disseminate the Primary Care Bioterrorism Needs Assessment, to develop training materials, and to collect information from focus groups.

California Association of Neonatologists (CAN), and Stanford University

The CMS and MCAH/OFP Branches are working with these groups on a perinatal and neonatal morbidity and mortality reporting system that is providing valuable information regarding quality of care and will serve as a basis for quality improvement in participating hospitals (CPQCC). Seventy percent of CCS approved NICUs are submitting their CCS data through CPQCC for CY 2004 with the anticipation that all 120 CCS approved NICUs will submit their CCS data for CY 2005 through CPQCC. CCS continues to work with CAN, and, through representation by CAN members on the CMS NICU Technical Advisory Committee and representation of CMS on the CAN Executive Board, there is ongoing dialogue on issues of concern.

Children's Specialty Care Coalition

The Children's Specialty Care Coalition is an organization of pediatric specialty and subspecialty providers practicing at CCS approved tertiary hospitals and SCCs. The CMS Branch has been working closely with the organization to successfully adopt the web-based CCS authorization system. There have also been ongoing discussions on ways to increase the number of qualified providers participating in the CCS program.

California Conference of Local Health Officers (CCLHO)

CMS works with this association on issues related to county program operations for CSHCN, preventive health services for children, and the CMS Net Data system. MCAH/OFP Branch leadership participates in ongoing activities and committees of the CCLHO.

CCLHO is actively involved in issues affecting CMS programs such as cost containment proposals, administrative allocations, and program funding.

California Children's Hospital Association (CCHA)

The Children's Hospitals are important providers of services to children in the CCS program. The CMS Branch has been working closely with the hospitals for the past year to implement a web-based CCS authorization system that will streamline authorizations and accelerate payment. The goal is to have the system fully implemented by early summer. The hospitals have had to modify their existing systems, and the CMS Branch has provided technical assistance and ongoing consultation in this collaborative effort. The CMS Branch is collaborating with CCHA and the California Medical Assistance Commission (CMAC) on developing hospital payment and policy for inhaled nitric oxide therapy in neonates and for botulism immune globulin.

Other Professional Organizations

The CMS Branch collaborates with the California Dental Association, the California Association of

Orthodontists, the Oral Health Access Council, the California Orthopedic Surgeons Association, the California Association of Home Health Agencies, and the Hemophilia Council and Foundations to improve working relationships, recruitment of providers, and to address barriers to access of services.

Managed Care Plans

There is ongoing collaboration between CMS and the California HealthCare Foundation, Family Voices and the Children's Regional Integrated Service System (CRISS) on the following projects: 1) CSHCN medical home project, and 2) statewide operational problems that occur with the carve-out of CCS services in Medi-Cal and HF managed care plans.

## F. HEALTH SYSTEMS CAPACITY INDICATORS

Health Status Capacity Indicator 01

Health System Capacity Indicator 01 (HSCI-1) is the rate per 10,000 for asthma hospitalizations among children less than five years old. The child asthma hospitalization rate increased from 23.9 per 10,000 in 1998 to 30.6 in 2002 and 32.6 in 2003. This is consistent with national increases in asthma prevalence between 1980 and 2000 [49] but contrary to the Healthy People 2010 objective to reduce the rate to no more than 25 per 10,000.

The California Asthma Initiative (CAI), funded by First Five, targets children with asthma from birth to five years of age. There are two CMS CAI components: the Asthma Treatment Services (ATS) Project and the CHDP Asthma Project. ATS provides outpatient visits, medications, medication administrative devices, and patient/parent education in three communities -- Oakland, Los Angeles and San Diego. Funding for the ATS Project expires at the end of FY 2004-2005 and will not be renewed.

Under the CHDP Asthma Project, the CMS Branch has provided training to over 5,200 pediatric providers in asthma management. This project has resulted in CHDP providers including asthma assessments in their periodic health assessments for 1.3 million CHDP children under the age of five years. Funding has also been used to develop and provide asthma education materials for children and parents. Funding for the CHDP Asthma Project expires at the end of FY 2005-2006 and will not be renewed.

Health Status Capacity Indicator 02

Health Systems Capacity Indicator 02 (HSCI-2) is the percent of Medi-Cal enrolled children less than one year of age who received at least one CHDP health assessment in the reporting year. In FY 2002-2003, HSCI 02 was 67.3 percent, up slightly from 66.2 percent in the previous year. The numerator is probably under-estimated (for both years) since an increasing number of children are enrolled in Medi-Cal Managed Care (MCMC) plans, and there is under-reporting of data from these plans as the PM 160 is an "information only" form. (The methodology for calculating this measure was changed in FY 2001-2002, and numbers reported previously are not directly comparable to numbers reported here.)

The Memoranda of Understanding between MCMC plans and local CHDP programs continues. Each local CHDP program coordinates with MCMC plans to develop a procedure for working together. DHS provides technical assistance to local CHDP programs and MCMC plans to resolve problem areas. The CHDP program provides outreach to providers and children and their families (such as Health Fairs). The CMS Branch has been collaborating with the California Medical Home Project and the LA Medical Home Project. LA County CCS is working with LA Care MCMC Plan for better coordination of care by the medical home.

Quarterly meetings between CHDP programs and MCMC plans are again being scheduled now that budget constraints have been removed. The CMS Branch has been participating in MCMC planning meetings in an effort to coordinate work on Facility and Medical Record Review Tools that are being updated by MCMC plans and the CHDP program. There is ongoing collaboration with MCMC plans on the Medical Home Project and on statewide operational problems that occur with the carve-out of CCS services in Medi-Cal and HF managed care plans.

Health Status Capacity Indicator 03

Health Systems Capacity Indicator 03 (HSCI-3) is the percent of Healthy Families (HF) enrollees under one year of age who received at least one CHDP health assessment. These data are not available. HF plans do not conduct CHDP health assessments, but instead perform preventive examinations based on the American Academy of Pediatrics guidelines. The HF Program relies on the Health Plan Employer Data and Information Set (HEDIS) to evaluate the performance of the health plans.

Health Status Capacity Indicator 04

Health Systems Capacity Indicator 04 (HSCI-4) is the percent of women (ages 15 through 44) with a live birth during the year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index. The Kotelchuck Index is a measure of prenatal care utilization that includes both the mother's timing of initiation of prenatal care and the number of prenatal care visits compared to those recommended by the American College of Obstetricians and Gynecologists.

The Kotelchuck Index shows steady improvement in prenatal care utilization in California from 1989 through 2003. In 2003, 78.7 percent of California women received adequate prenatal care, up from 77.8 percent in the previous year. For purposes of comparison, the rate was 58.7 percent in 1989. [50] While much progress has been made, the 2003 rate is still considerably lower than the national Healthy People 2010 goal of 90 percent.

A review of the distribution of this indicator by race/ethnicity (2003) shows moderate disparities. It ranges from a low of 67.1 percent for American Indians and Pacific Islanders to a high of 81.9 percent for Whites. Hispanics and African-Americans are closer to the upper end of the range, at 76.8 and 77.3 percent, respectively.

Several strategies have been used in California to improve prenatal care utilization, including expansion of Medi-Cal eligibility criteria, improved access to Medi-Cal through presumptive and continuous eligibility, a waived assets test, and reduced application paperwork. These were accomplished in California in the late 1980s, and the improvements in the rates in the 1990s are probably at least partly attributable to these changes. Also, several state programs support improvements in adequate prenatal care through direct and indirect delivery of services and support; these include the Comprehensive Perinatal Services Program, the Adolescent Family Life Program, the Adolescent Sibling Pregnancy Prevention Program, WIC, the Black Infant Health Program, and the American Indian Infant Health Initiative.

Health Status Capacity Indicator 05

Health Systems Capacity Indicator 05 (HSCI-5) compares Medicaid and non-Medicaid in the following four areas:
> HSCI-5a: Percent of low birth weight (<2,500 grams)
> HSCI-5b: Infant death rate

> HSCI-5c: First trimester prenatal care
> HSCI-5d: Percent of women with adequate prenatal care (Kotelchuck Index)
Payment source data are obtained from birth certificates. Non-Medicaid payment source includes private insurance, self-pay, no charge, other government programs, and medically indigent. In California, Medicaid is called Medi-Cal.

HSCI-5a, the percent of low birth weight (<2,500 grams), was quite similar for Medi-Cal and non-Medi-Cal in 2003: 6.7 percent and 6.5 percent, respectively. This is similar to the previous year. Neither payment source reached the Healthy People 2010 target of 5.0 percent.

HSCI-5b, the infant death rate, was higher among Medi-Cal births (6.1 per 1,000) than among non-Medi-Cal births (4.7 per 1,000) for 2002 (most current data available). Both rates are similar to rates for the previous two years. Neither the Medi-Cal population nor the non-Medi-Cal population has achieved the Healthy People 2010 goal of 4.5, but the rate in the non-Medi-Cal population is close.

HSCI-5c, the percent of women entering prenatal care in the first trimester, was lower for Medi-Cal births (82.3 percent) than for non-Medi-Cal births (91.2 percent) in 2003. Both were up slightly from last year, when they were 80.8 and 90.6 percent, respectively. The non-Medi-Cal population achieved the Healthy People 2010 goal of 90 percent.

HSCI-5d is a comparison for Medi-Cal and non-Medi-Cal of the percent of live births in which the woman had adequate prenatal visits. The adequacy of prenatal care is measured, as in HSCI 4, as the percent of women (ages 15 through 44) with a live birth during the year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index. By this measure, 75.8 percent of Medi-Cal women and 80.7 percent of non-Medi-Cal women had adequate prenatal care in 2003, up from 74.6 and 80.1 percent, respectively, in the previous year. Both groups are lower than the national Healthy People 2010 goal of 90 percent.

One of the reasons that utilization of prenatal care in the first trimester is lower than optimal is that the number of unintended pregnancies remains high. Among low-income women surveyed in the 1995 National Survey of Family Growth, 61 percent classified their pregnancies as unintended, compared with 41 percent of women whose incomes exceeded 200 percent of the FPL. [51]

Medi-Cal eligibility increases prenatal visits, but Medi-Cal's beneficial effects are limited by the program's inability to encourage women to seek care earlier in their pregnancy. MCAH programs are critical in identifying women in need of prenatal care at early stages in the pregnancy through community connections, community outreach, hotlines, and similar interventions; they are also critical in providing social support services, case management and client follow-up.

## Health Systems Capacity Indicator 06

Health Systems Capacity Indicator 06 (HSCI-6) compares the income eligibility requirements for 2003 for Medicaid and the State Children's Health Insurance Program (SCHIP) for the following three populations:
> HSCI 6a: Infants (ages 0 to 1)
> HSCI 6b: Children ages 1 to 19
> HSCI 6c: Pregnant women
In California, the SCHIP program is called Healthy Families (HF).

HSCI 6a: Infants (ages 0 to 1). Infants are eligible for Medi-Cal if the family income is at or below 200 percent of the FPL. HF is more inclusive, using an eligibility level of at or below 250 percent of FPL.

HSCI 6b: Children ages 1 to 19. Children age 1-5 are eligible for Medi-Cal if the family income is at or below 133 percent of FPL; for children age 6-19, the eligibility level is 100 percent of FPL. HF has an eligibility level of 250 percent of FPL for children age 1 - 19.

HSCI 6c: Pregnant women. Pregnant women are eligible for Medi-Cal if the family income is at or below 200 percent of the FPL. Pregnant women are not eligible for HF.

There were no changes in the income eligibility requirements for these three groups in the last year.

Health Systems Capacity Indicator 07

Health Systems Capacity Indicator 07 (HSCI-7) is the percent of EPSDT eligible children (CHDP in California) aged 6 through 9 years who received any dental services during the year. The goal of this indicator is to increase dental health services to Medi-Cal eligible children at an important stage of dental development. In FY 2003-2004, HSCI-7 was 35.5 percent. The result was 48.1 percent in FY 2002-03.

Medical Care Statistics has been providing the numerator and denominator for this performance measure the past few years, but for FY 2003-04, the numerator and denominator were provided by Medstat using the Management Information System/Decision Support System (MIS/DSS) data base. The numerator for the measure was similar to 2002-03, but the denominator was much larger, most likely secondary to using different aid codes in determining the EPSDT eligible children. The performance measure for 2003-04 cannot be compared with prior years.

It is anticipated that new CHDP tools such as the two-sided full color laminated "PM 160 Dental Guide" that was distributed in 2003 to all CHDP providers will improve the quality of dental screenings and facilitate more precise referrals to a dentist. The CHDP program is making providers aware of a statewide training program to address early childhood caries through the First 5 California Initiative. CHDP is encouraging medical providers to attend one of the local trainings. Also, the CHDP program is making CHDP providers aware of the MCH website, www.mchoralhealth.org/PediatricOH/index.htm, that includes seven oral health teaching modules for pediatricians; this instruction should make screening providers more cognizant of the importance of dental referrals and particularly timeliness of these referrals.

Current activities related to this indicator include: the CHDP Gateway covers dental services for pre-enrolled children for up to two months and has increased access to dental services for this group of children; the CHDP Gateway offers the opportunity for children to apply for permanent enrollment in Medi-Cal or HF with dental services as benefits.

The Dental Subcommittee of the CHDP Executive Committee continues to work on dental updates and revisions to the CHDP Health Assessment Guidelines and other CMS publications to broaden the knowledge-base of providers, local program staff, families, and communities. The Subcommittee is currently working on a portfolio of information entitled "CHDP Medical Provider Oral Health Guide" which includes such topics as transmission of bacteria, prenatal oral health, the age one dental referral, anticipatory guidance, a visual guide for screening infants and toddlers, caries risk factors assessment, fluoride varnish, xylitol, fluoride supplementation, eruption patterns and available resources.

Health Systems Capacity Indicator 08

Health Systems Capacity Indicator 08 (HSCI-8) is the percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State CSHCN Program. HSCI-8 is 10.9 percent for FY 2004-05. The numerator, 8,944, is the number of children under 16 years of age estimated to have SSI and receiving rehabilitative services. The denominator, 82,343, is the number of SSI beneficiaries under age 16. This is the first year that data have been available for this specific age group (less than

16 years of age), so no comparative data for previous years are available.

There have been several changes in how this indicator has been calculated over the last few years. The current methodology is as follows. The numerator is the number of children in the CMS Net system with eligibility aid codes of 20 or 60 (disabled children with SSI), most of whom will be receiving Medical Therapy Program (MTP) services. The number from CMS Net is then extrapolated to all counties. The denominator is from the Social Security Administration Office of Policy, Children Receiving SSI for December, the midpoint of the current fiscal year, for children under 16 years of age.

The CCS MTP provides physical therapy, occupational therapy, and Medical Therapy Conference (MTC) services to children who meet specific medical eligibility criteria. The majority of children have cerebral palsy. The children eligible for the MTP do not have to meet the CCS financial requirement to receive therapy or conference services through the MTP. Services are provided in a Medical Therapy Unit (MTU), an outpatient clinic setting that is located on a public school site. Coordination of services in the MTU is under the medical management of a physician/therapy team.

The CMS program introduced statewide outcome measurements for the MTP effective July 2004. Two tools developed for the MTP for program management are the (1) Functional Improvement Score, to measure the amount of functional change that a child achieves in a 6-12 month period, and the (2) Neuromotor Impairment Severity Scale, to measure the amount of neuromotor impairment for children with cerebral palsy or similar upper motor neuron conditions.

As in past years, the CMS Branch notes that many children who are SSI beneficiaries have mental health and developmental disabilities or delays and are not medically eligible for CCS but are eligible for other state-funded services such as regional center services.

Health Systems Capacity Indicator 09

Health Systems Capacity Indicator 09 (HSCI-9) describes MCH data capacity in the following three areas:
> HSCI 9a: General
> HSCI 9b: Adolescent tobacco use
> HSCI 9c: Obesity/overweight

HSCI 9a is general MCH data capacity. There are many sources of MCH data in California, including data from birth and death certificates; hospital discharge data; several statewide surveys, including the Maternal and Infant Health Assessment Survey (MIHA), the California Women's Health Survey (CWHS), the California Healthy Kids' Survey (CHKS), and the California Health Interview Survey (CHIS); and program data.

The MCAH/OFP Branch has maintained linked files of infant birth and death certificates for all deliveries in California since 1965. These data are used for a variety of research endeavors including the assessment of fetal and infant mortality rates across the state and over time. These data are provided (confidentially) to hospitals annually and are one of the primary tools for reducing fetal and infant mortality rates and improving quality of care.

MCAH/OFP also has access to hospital discharge data through the California Office of Statewide Health Planning and Development (OSHPD). OSHPD has administrative and clinical data from all licensed hospitals in California, including data on population demographics, hospital/clinic characteristics, payor source, births and deliveries, and other conditions, procedures, and injuries.

MCAH/OFP has access to linked birth, hospital discharge, and death files, for surveillance of maternal mortality and morbidity and indicators of maternal quality of care.

MCAH/OFP has the capacity to link birth certificate data and WIC eligibility files, as was done in 1999. Because of budgetary constraints, it has not been done in the past three years, but it is anticipated that this linkage can be resumed within the next year or two.

Although the MCAH/OFP Branch does not currently have the ability to link birth certificate and newborn screening files, plans are underway for MCAH/OFP to work with the GDB to accomplish this. DHS does have the capacity to link birth certificate files with Medicaid files.

MCAH/OFP's MIHA survey is an annual survey of women delivering live infants in California. The survey is modeled after CDC's Pregnancy Risk Assessment Monitoring System (PRAMS) and is self-administered 10-14 weeks after birth to a stratified, random sample of approximately 3,500 participating women. Strata are by maternal region of residence, race/ethnicity, and education. Surveys are available in English and Spanish. The first year of data collection was completed in 1999. Covered issues include demographics, intendedness of pregnancy, utilization of health care, breastfeeding, and risk behaviors before and during pregnancy, including use of folic acid supplementation. Birth outcomes are provided through linkage with birth certificate data. Questions may be rotated into and out of MIHA depending on data needs and emerging issues. The administration of this survey is contracted out to UCSF, and UCSF staff collaborate with MCAH/OFP staff on analysis and reporting of survey results.

The California Women's Health Survey (CWHS), conducted under the auspices of the California Office of Women's Health, is an annual, computer-assisted, random-digit dialed telephone survey in which 200 questions are answered by approximately 4,000 women. The survey is anonymous and is conducted in English and Spanish. Covered issues include health insurance status, family planning, sexually transmitted infections, pregnancy (including knowledge and use of folic acid), mental health, and lifestyle issues such as food/nutrition and exercise. MCAH/OFP staff sit on the CWHS advisory group, contribute questions to the survey, and prepare and present findings.

The California Health Interview Survey (CHIS) is a collaborative project of DHS, the UCLA Center for Health Policy Research, and the Public Health Institute. CHIS is a bi-annual telephone survey of adults, adolescents, and children from all parts of the state. The 2001 and 2003 surveys each covered 42,000 - 55,000 households, enough to allow for statewide and some local level analysis. Covered issues include health insurance coverage, alcohol and tobacco use, asthma, diabetes, mental health, oral health, overweight and obesity, and lifestyle issues, including food/nutrition and exercise. MCAH/OFP staff sit on several CHIS Technical Advisory Groups, helping to develop topic areas and survey questions, and participating in the analysis of survey data.

The MCAH/OFP Branch also collects and maintains data on its various programs, including the Adolescent Family Life Program, the Adolescent Sibling Pregnancy Prevention Program, the Black Infant Health Program, the California Diabetes and Pregnancy Program, the Comprehensive Perinatal Services Program, the Fetal Infant Mortality Review Program, and the Sudden Infant Death Syndrome Program. Data elements vary by program, but generally cover number of clients served, client sociodemographics, number of home visits, and utilization of services. Program files can usually be linked to birth and/or death files.

HSCI 9b is data capacity for adolescent tobacco use. Data on adolescent tobacco use in California are currently obtained from two sources: the California Health Interview Survey (CHIS) and the California Student Tobacco Survey (CSTS). CHIS is a random digit dial telephone survey that is conducted every two years. It is the largest state health survey, with over 42,000 California households surveyed in 2003. CHIS data, which are available by age (as opposed to grade level), are used for State Performance Measure 09 (percent of youth age 12-17 who report smoking cigarettes in past 30 days). CSTS, used by the DHS Tobacco Control Section, is a school-based survey of middle and high school students.

HSCI 9c is data capacity for obesity/overweight. The PedNSS, administered through CDC, provides a valuable framework for tabulating and interpreting state-specific information on the nutritional characteristics of low-income children. California submits data from all CHDP health assessments to PedNSS, including length/height, weight, birthweight, hemoglobin/hematocrit, ethnicity/race, and gender. CDC uses this data and data from other sources to produce multiple tables for growth and anemia in children from birth to 20 years of age.

In California, data similar to the Youth Risk Behavior Survey are collected by the California Healthy Kids Survey (CHKS). The CHKS is administered by the California Department of Education and gathers data on behaviors such as physical activity and nutritional habits; alcohol, tobacco, and other drug use; school safety; and environmental and individual strengths and assets.

# IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

## A. BACKGROUND AND OVERVIEW

Performance Reporting

California's Title V performance reporting currently includes a total of twenty-seven measures: eighteen national performances measures (NPM) mandated by HRSA and nine additional measures chosen by the state. In FY 2005-2006, the current state performance measures (SPM) will be reviewed and updated based on the needs and priorities identified in the 2005 Needs Assessment.

The nine SPM in this report, which are based on the 2000 Five Year Needs Assessment, include the following:

SPM 1: The percent of children whose family income is less than 200 percent of the FPL who received at least one preventive medical exam during the fiscal year.

SPM 2: The percent of low-income children who are above the 95th percentile of weight-for-height, or overweight.

SPM 3: The rate of deaths per 100,000 children aged 1 through 4 years caused by drowning in swimming pools.

SPM 4 : The rate of deaths per 100,000 adolescents aged 15 through 19 years caused by homicide.

SPM 5: The rate of deaths per 100,000 adolescents aged 15 through 19 years caused by motor vehicle injuries.

SPM 6: The incidence of neural tube defects (NTDs) per 10,000 live births plus fetal deaths among counties participating in the California Birth Defects Monitoring System.

SPM 7: The percent of CCS enrolled children registered in CMS Net, the statewide automated case management and data collection system for CCS.

SPM 8: The percent of women 18 years or older reporting intimate partner physical abuse in the past 12 months.

SPM 9: The percent of youth aged 12-17 years who report smoking cigarettes in the past 30 days.

The national and state performance measures cover the four levels of the MCH pyramid: Direct Health Care Services, Enabling Services, Population-Based Services, and Infrastructure Building Services. For a discussion of specific programs associated with each performance measure, please refer to Sections IV C (NPMs) and IV D (SPMs). Figures 4a and 4b (Performance Measures Summary Sheet) show where the state's many activities fit on the MCH pyramid.

Data on performance measures are included in two parts of this report - on the data forms and in the narrative. The most recent data available for most performance measures is for 2003. Where the forms require data for 2004 that are currently unavailable, estimates are made based on data from 2003.

Please refer to the Attachment for information on the development of the annual objectives for the performance measures.

## B. STATE PRIORITIES

State Priorities

The 2005 five-year needs assessment identified ten priorities for maternal, child, and adolescent health in California. The priorities encompass all levels of the MCAH health services pyramid and in some cases span pyramid levels. The ten priorities for Title V activities in California are:

> Enhance preconception care and work toward eliminating disparities in infant and maternal morbidity and mortality.

> Promote healthy lifestyle practices among MCAH populations and reduce the rate of overweight children and adolescents.

> Promote responsible sexual behavior in order to decrease the rate of teenage pregnancy and sexually transmitted infections.

> Improve mental health and decrease substance abuse among children, adolescents, and pregnant or parenting women.

> Coordinate to develop and implement a system of timely referral between mental health, developmental services, social services, special education services and CCS.

> Improve access to medical and dental services, including the reduction of disparities.

> Expand the number of qualified providers participating in the CCS program, e.g., medical specialists, audiologists, occupational and physical therapists, and nutritionists.

> Increase the number of family-centered medical homes for CSHCN and the number/percent of CCS children who have a designated medical home.

> Decrease unintentional and intentional injuries and violence, including family and intimate partner violence.

> Increase breastfeeding initiation and duration.

## Relationship of Priorities, Performance Measures, and Capacity

In the course of the five-year needs assessment which was completed in the summer of 2005, new priority needs were identified and are listed above. Performance measures based on the new priority needs will be developed in the coming year.

## Parent and Community Involvement

California DHS recognizes parent and community involvement as critical to the development of responsive, family centered, and community based systems of care. While this has been a long-standing state priority, MCAH/OFP and CMS are making special efforts this year, in accordance with the federal Title V Reviewers' recommendations in August 2004, to strengthen existing partnerships among families, communities and policymakers and to provide more information about those partnerships in this report.

Parent and community input has been solicited and incorporated into the Title V Five Year Needs Assessment. Counties obtained parent and community input via surveys, focus groups and direct participation in the needs assessment process. Twenty-seven counties reported collecting survey data from more than 2,000 clients, parents and other family members. Sixteen counties reported having conducted focus groups. Eight counties reported that clients, family members, or community representatives actively participated in their needs assessment process.

An excellent example of client/family input at the local level is the Young Mothers Advisory Council (YMAC) of San Mateo County, a project of the San Mateo County Adolescent Family Life Program. The mission of YMAC is to improve the quality of life for pregnant and parenting teens and their families by influencing public policy at various levels through a council of teen parents. YMAC is currently in its fourth year of providing an internship program for select teen parents to practice advocacy and develop leadership skills.

Stakeholder groups consisting of parents, clients and community leaders are currently being developed for the Black Infant Health Program and the Adolescent Family Life Program. Initial meetings are planned for the summer or fall of 2005. Program modifications based on the recommendations of stakeholder groups are anticipated within the next 15 months. The Adolescent Health Collaborative is looking at ways to better involve youth in program planning and service improvement, including how to involve youth in planning their adolescent health conference.

The 17 local BIH agencies have community advisory boards composed of former clients and community leaders as well as health professionals and agency representatives. The advisory boards identify gaps and barriers to services for African Americans and provide input for needs assessment, program planning, and community awareness events. Some community advisory boards, such as The Black Infant Health Leadership Coalition in Fresno and the Black Women's Health Task Force in Pasadena, also partner with local churches and community agencies to provide information and education to providers and the community about racial health disparities.

The State Early Childhood Comprehensive Systems Project (SECCS) is another excellent example of parental involvement in program planning and implementation. SECCS, funded by HRSA, provides state-level leadership for early childhood health programs to help California's children be emotionally, socially, and physically healthy and ready for kindergarten. The project coordinates a myriad of health-related programs at the state and local levels, including: DHS, DMH, DSS, CDE, DDS, First Five California, MRMIB; organizations such as the American Academy of Pediatrics, Family Voices of California, March of Dimes, Easter Seals, Interagency Coordinating Council for Children with Disabilities; and representatives of faith-based organizations (e.g. California Council of Churches). Parent input is obtained through focus groups, individual interviews, and inclusion on the Steering Committee. Parental participation and input is critical to the development and completion of the SECCS statewide needs assessment, environmental scan and strategic plan. Three members of the SECCS Steering Comittee are parents of children with special healthcare needs.

Pediatric Special Care Centers (SCCs) and hospitals that treat CSHCN and wish to become CCS-approved must meet specific criteria for provision of family-centered care (FCC). During the hospital or SCC review, the following are assessed: the level of parental involvement in treatment decision making; sharing of reports with families; the degree of parent/patient involvement in advisory committees that set policies and procedures; and availability of healthy sibling and parent visiting. As part of the review process of the SCC or hospital, the CMS Branch sends a follow-up report to the facility with FCC recommendations.

The CCS program facilitates FCC services for families of CSHCN. CCS staffing standards allow a parent liaison position in each county CCS program to enable FCC. County CCS programs assist families in accessing authorized services. Many families live long distances from the site of appropriate pediatric specialty and subspecialty care. The program provides reimbursement for travel expenses (gas, bus tickets, taxis), meals for extended stays, and motel rooms for families when there are extended hospital stays.

The Children's Regional Integrated Service Systems (CRISS), which is comprised of fourteen CCS county programs, has a Family-Centered Care (FCC) Work Group that meets bimonthly; this Group plans, develops and sponsors an annual conference (in addition to assisting with other conferences workshops, resource fairs, and addressing many issues regarding family-centered care). The annual conference for November 5, 2004 was "Sexuality and Youth with Disabilities: What Do You Say and

How Do You Say It?" which included an expert panel and an interactive workshop. CCS staff, family support agency staff and parent leaders attended, as well as staff from Regional Centers and Special Education.

Participants in the CRISS FCC Work Group began development of a medical home parent binder last year. Sample binders were circulated, including the MCHB Children's Health Status Assessment, the Partnership Health Plan Parent Resource Network, CARE Parent Notebook, the Health and Education Passport Document, and Parents Helping Parents' Passbook. The group reviewed and commented on the prototypes, and invited family members had many useful suggestions among which were a universal medical release, downloadable PDF forms on an accessible website, and business card holder.

The CMS Branch is directing a Champions for Progress Center Incentive Award for FFY 2004-05 to further the development and implementation of a community-based system of care for CSHCN and their families. CSHCN and their families are served by a variety of public and private agencies throughout California; however, there has been no sustained statewide effort to identify and plan for the coordination of their activities. This project will convene a group of key stakeholders, with past investments in and knowledge of the system of care for CSHCN and their families, including the State's Title V leadership and family representatives, to meet bimonthly for twelve months to develop an action plan to address the CSHCN Title V performance measures from the National Survey.

The project will also build on existing coalitions and projects, and past efforts to develop a long-term, strategic plan for serving CSHCN; and it will identify resources within California to carry out the activities defined in the strategic plan. A monitoring and evaluation strategy will be developed to assure continued improvement and progress toward achievement of the performance measures for CSHCN.

These objectives will build on previously successful, but often uncoordinated efforts on behalf of CSHCN in California including: Family Voices, a statewide effort to improve the lives of children with special health care needs through information and education provided to families, professional, policymakers, and communities at large; CRISS (a collaborative of family support organization representatives, pediatric providers, statewide organization representatives, Family Voices, and fourteen County CCS programs in Northern California), dedicated to building an effective regional system of care for children enrolled in CCS; the California Medical Home Project, a statewide effort to improve access to care for CSHCN by increasing the quantity of high quality medical homes in the state; CCS Workgroup, a group of key stakeholders in Los Angeles County addressing issues related to systems improvement, in particular within the local CCS program; Medi-Cal Managed Care Division Task Force for Children with Special Health Care Needs, a group of representatives from statewide programs and projects convened to make recommendations to the Division on federal Balanced Budget Act protections for children with special needs enrolled in Medicaid managed care. All of these groups have worked successfully to achieve their own goals and objectives for the population, but there have not been sustained, coordinated efforts among these groups to address the performance measures or to develop a statewide comprehensive plan of service system improvements for the children and their families.

The State Transition Workgroup, recently formed, includes a family advocate, a parent advocate, a CCS client, and a parent of a child receiving CCS services. LA County CCS has a paid parent on staff who is the Chief of Family Support. This parent staff member is helping the LA CCS program be more responsive to the needs and issues of families and is also available to work with the State CMS Branch and Regional Offices on issues affecting families.

## C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with*

*condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | | | 99 | 99 | 99 |
| Annual Indicator | | 98.4 | 98.7 | 99.5 | 99.5 |
| Numerator | | 375 | 376 | 397 | |
| Denominator | | 381 | 381 | 399 | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 99.5 | 99.5 | 99.5 | 99.5 | 99.5 |

**Notes - 2002**

Source: State of California, Department of Health Services, Genetic Disease Branch, 2002 Newborn Screening Records.

**Notes - 2003**

Source: State of California, Department of Health Services, Genetic Disease Branch, 2003 Newborn Screening Records.

**Notes - 2004**

A manual indicator is reported for 2004 based on 2003.

a. Last Year's Accomplishments

California has achieved near universal coverage for newborn screening for genetic, metabolic and hematological disorders. NPM 01 is the percent of infants with positive screens who received appropriate follow-up as defined by their State. The rate for California in 2003 was 99.5 percent, up from 98.7 percent in 2002 and 98.4 percent in 2001. The annual objective of 99 percent for 2003 was achieved.

In 2003, as in the previous year, the annual objective of 99 percent was achieved for three of the four conditions for which screening tests were performed. Of the cases confirmed positive for phenylketonuria (PKU), congenital hypothyroidism or galactosemia, 100 percent received appropriate follow-up (34/34 for PKU, 275/275 for congenital hypothyroidism, and 6/6 for galactosemia). The percent receiving appropriate follow-up for sickle cell disease was 97.6 percent (82/84), up from 95.9 percent (93/97) in 2002 and 94.0 percent (94/100) in 2001. One of the reasons that follow-up may not reach 100 percent is the inability to track all affected children who relocate.

The Genetic Disease Branch (GDB) conducts two large screening programs -- prenatal and neonatal -- for the prevention, detection and/or treatment of disorders that can be detected and prevented or treated prenatally or neonatally. Services include counseling, testing, and educational materials for patients, as well as public information and professional education.

Genetic screening is a statutorily mandated service available to all pregnant women (prenatal screening) and newborns (newborn screening).

The expanded alpha fetoprotein program is a prenatal screening program for the detection of open neural tube defects, abdominal wall defects, Smith-Lemli-Opitz Syndrome, and chromosomal anomalies such as trisomy 21 and trisomy 18. Women with positive screening tests are referred to State-approved Prenatal Diagnosis Centers under contract with GDB. Services offered at these Centers include genetic counseling, high-resolution ultrasound, and amniocentesis.

The testing panel for newborns currently includes primary screening for PKU, hypothyroidism, galactosemia, and hemoglobinopathies. The program follows the infant until a confirmatory diagnosis is received and the infant's treatment is established with a health care provider.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. The Genetic Disease Branch (GDB) screens for genetic and congenital disorders, including testing, follow-up and early diagnosis of disorders to prevent adverse outcomes or minimize the clinical effects. | X | | | |
| 2. The GDB ensures quality of analytical test results and program services by developing standards and quality assurance procedures, and monitoring compliance with them. | | | | X |
| 3. The GDB fosters informed participation in its programs through a combination of patient, professional, and public education, and accurate and up-to-date information and counseling. | | X | | |
| 4. The GDB is expanding its Newborn Screening Program to include over 40 additional metabolic conditions detectable via Tandem Mass Spectrometry. | X | | | |
| 5. Guidelines are being developed for diagnostic follow-up and treatment of the new disorders for which screening is available. | | | | X |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The GDB screens for genetic and congenital disorders, including testing, follow-up and early diagnosis, in order to prevent adverse outcomes and minimize clinical effects. The GDB ensures quality of analytical test results and program services by developing standards and quality assurance procedures, and monitoring compliance with them. The GDB fosters informed participation in its programs through a combination of patient, professional, and public education, as well as accurate, up-to-date information and counseling.

The GDB has recently been authorized to expand its Newborn Screening (NBS) Program to include over 40 additional metabolic conditions detectable via Tandem Mass Spectrometry (MS/MS) as well as classical congenital adrenal hyperplasia (CAH), including the salt-wasting and simple virilizing forms. Based on a three-year evaluation process supported by HRSA that

included laboratory data, along with follow-up, diagnosis, treatment, and outcome data, guidelines are being developed for diagnostic follow-up and treatment of the new disorders for which screening is available. The NBS Program has been preparing for expansion for the past year, including pilot testing. The CMS Branch has participated at GDB meetings for the development of the expanded program.

All the conditions for which the NBS program screens, including the new additions, are CCS-eligible; and the GDB and the CMS Branch are collaborating to ensure that infants identified with abnormal screening results from the current and expanded testing receive prompt diagnostic evaluations at one of the CCS approved Metabolic Special Care Centers (SCC) in the state. A CCS policy letter and a letter to the SCCs that will be involved in the evaluations are being prepared. The county CCS programs will be expediting GDB referrals so that infants with suspected metabolic illness can be identified and treated promptly, thereby possibly preventing premature death and/or serious disabilities.

### c. Plan for the Coming Year

The expansion of the newborn screening program to include both congenital adrenal hyperplasia and the MS/MS screening discussed above will be implemented in the coming year. With this expansion, the mandatory newborn screening is expected to be able to identify 625 newborns per year with one or more of the many metabolic, endocrine, or hemoglobin disorders screened for by the program.

GDB will continue to provide prenatal screening and follow-up services, as well as services related to patient education and counseling, public information and professional education. State and local agencies -- including GDB, the CMS Branch, CCS-approved SCCs, GDB NBS Coordinators, local County CCS programs, and Area Service Center Project Directors -- are working collaboratively to ensure that infants, identified with positive screening reports, are quickly evaluated, diagnosed, and appropriately treated and that families are informed and supported throughout the process.

## Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | 48.5 | 49.5 |
| Annual Indicator | | | 47.6 | 47.6 | 47.6 |
| Numerator | | | | | |
| Denominator | | | | | |
| Is the Data | | | | | |

| Provisional or Final? | | | | Final | Final |
|---|---|---|---|---|---|
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 50.5 | 51.5 | 52.5 | 53.5 | 53.5 |

**Notes - 2002**

The 2002 indicator is based on the State estimates from SLAITS.

This measure is new for FY 2002. It is the percent of CSHCN age 0 to 18 years whose families partner in decision-making at all levels and are satisfied with the services they receive.
Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2001.

**Notes - 2003**

The 2003 indicator is pre-populated from 2002 and is based on the State estimates from SLAITS.

This measure, new for FY 2002, is the percent of CSHCN age 0 to 18 years whose families partner in decision-making at all levels and are satisfied with the services they receive.
Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2001.

**Notes - 2004**

The 2004 indicator is pre-populated from 2002 and is based on the State estimates from SLAITS.

This measure is the percent of CSHCN age 0 to 18 years whose families partner in decision-making at all levels and are satisfied with the services they receive.
Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2001.

## a. Last Year's Accomplishments

NPM 02 is one of five measures (see also NPM 03, 04, 05, and 06) taken from the National Survey of CSHCN. The Special Population Surveys Branch of the CDC National Center for Health Statistics conducted the telephone survey from October 2000 to April 2002 and identified approximately 750 children with special needs in each state. Based on this survey, 47.6 percent of CSHCN age 0 to 18 have families partnering in decision making at all levels and are satisfied with the services they receive. The next survey will be conducted January 2005 through December 2006.

Accomplishments related to this measure over the past year include:

1) An increasing number of County CCS programs are considering or in the process of adding parent liaisons to their staff.

2) The Children's Regional Integrated Service Systems (CRISS) which comprises 14 CCS county programs has a Family-Centered Care (FCC) Work Group that meets bimonthly; this Group plans, develops and sponsors an annual conference (in addition to assisting with other conferences workshops, resource fairs, and addressing many issues regarding family-centered care); annual conference for November 5, 2004 was "Sexuality and Youth with Disabilities: What Do You Say and How Do You Say It?" which included an expert panel and an interactive

workshop.

3) The CMS Branch established a performance measure for family participation in the CCS program. and over the past year counties evaluated their programs for a second year using this performance measure.

4) CCS and family support organizations sponsored a Spasticity Conference on October 23, 2004 (Family Resource Network) and a Family-Centered Care Conference (CARE Parent Network) on November 6, 2004.

5) Examples of CCS County activities include: Contra Costa County CCS in conjunction with CARE Parent Network establishing a Latino Family Advisory Council; and San Francisco CCS and Support for Families co-sponsoring a Resource Fair with 330 families attending; and a State-County joint workshop on CCS and FCC at the 2nd Annual International Conference on FCC in San Francisco in February 2005.

6) CCS programs are partnering with Family Resource Centers in their areas.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. CMS collaborates on a federal MCHB grant for integrated community systems of care for CSHCN. | | X | | |
| 2. CMS contracts with Children's Regional Integrated Service Systems (CRISS) for reception and analysis of statewide CCS program Family Centered Care. (FCC) data. | | X | | |
| 3. CMS is directing Champions for Progress Award for development and implementation of community based systems of care for CSHCN. | | X | | |
| 4. CCS county programs are collaborating with agencies/families on workshops, resource fairs, and conferences for families. | | X | | |
| 5. CCS is partnering with family support organizations on FCC conferences. | | X | | |
| 6. CRISS is sending FCC survey (#2) to CCS programs and family resource centers for trends/comparison to survey #1. | | X | | |
| 7. More CCS counties implement staffing standards for inclusion of parent liaison. | | | | X |
| 8. CCS counties are including parents on CCS advisory committees. | | | | X |
| 9. CCS counties are evaluating their programs with a performance measure for family participation in the CCS program. | | | | X |
| 10. CRISS FCC Workgroup plans FCC trainings, conferences, monitors activities, and provides technical assistance for parent liaisons for county. programs | | | | X |

## b. Current Activities

Current activities around this measure include:

1) The CRISS FCC Work Group continues to meet bimonthly and county member representatives report on their FCC activities, share ideas and resources, and coordinate conferences, trainings and activities.

2) The FCC Work Group monitors FCC and transition activities, parent liaison services, and medical home projects.

3) More county CCS programs are hiring a parent liaison while others have parents from strong family support organizations sitting on their CCS advisory committees.

4) The FCC Work Group is providing technical assistance for CCS administrators for hiring or contracting a parent liaison.

5) County CCS programs are reporting on family participation in the CCS program.

6) Many counties are sending out or planning to send out family satisfaction surveys.

7) There is collaboration among counties and among counties and agencies to provide workshops, resource fairs, and conferences for families; these collaborations include parents and families in their planning and development.

8) CRISS continues to sponsor major conferences on FCC for CSHCN and provides technical assistance for transition planning in CCS programs.

9) San Mateo County is developing a multicultural parent task force.

10) Family members are participating on advisory committees or task forces in many counties, and are becoming involved in in-service training of CCS staff and providers.

11) The CRISS FCC Work Group is setting timelines and preparing to send out a Family-Centered Care survey in 2005 to CCS programs and family resource centers; the first survey was sent in 2002, and the current survey will help to determine if there are positive trends and then to analyze how and where these positive trends occurred.

12) A new CRISS Medical Therapy Program (MTP) Work Group had an initial meeting in April 2005; the Group will identify common challenges among MTP programs and consider potential solutions; therapy staff and family support staff are invited to the quarterly meetings.

13) The CMS Branch is directing a Champions for Progress Center Incentive Award for FFY 2004-05 to further the development and implementation of a community-based system of care for CSHCN and their families.

## c. Plan for the Coming Year

Plans for the coming year include:

1) County CCS programs will continue hiring parent liaisons.

2) The FCC Work Group will continue to meet bimonthly, monitoring FCC and transition activities, parent liaison services, and medical home projects, as well as providing resources and support for all counties in attaining parent liaison services.

3) County CCS programs will continue to evaluate their programs for family participation in the CCS program.
4) More family members will be participating on advisory committees, task forces, and in-service trainings of CCS staff and providers.

5) Medical therapy programs will continue to be targeted for FCC activities.

6) Collaborative workshops, conferences, and resource fairs will continue to occur.

7) The CRISS FCC Work Group will be planning and developing a November 4, 2005 annual conference entitled, "What Happens at 18: Conservatorship and Other Changes in Legal Rights?"

8) The newly formed CRISS MTP Work Group will be meeting quarterly.

9) A Federal MCHB grant has been awarded officially to the University Affiliated Program at USC/Children's Hospital LA for collaboration with CRISS and Family Voices of California for a 3-year project to implement integrated community systems of care for CSHCN; activities to promote systems of care for CSHCN will be expanded in the 14 CCS County region (involved with CRISS) and in Los Angeles, and state-focused activities will be launched.

10) Work will continue on the Champions for Progress Center Incentive Award for FFY 2004-05 to further the development and implementation of a community-based system of care for CSHCN and their families.

11) The CMS Branch will be receiving data and analyzed data regarding statewide CCS program family-centered care.

12) There will be two regional educational conferences, one each in Northern and Southern California that will include education on family-centered care topics for all CCS administrators, medical consultants, nurse consultants, social work consultants, parent health liaison/leaders, and therapists; conference planning will draw on the expertise of family support organizations, CCS programs, and providers; the conference presentations will model parent-professional collaboration.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| **Annual Objective and Performance Data** | **2000** | **2001** | **2002** | **2003** | **2004** |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | 45.5 | 46.5 |
| Annual Indicator | | | 44.7 | 44.7 | 44.7 |
| Numerator | | | | | |
| Denominator | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance | 48 | 50 | 52 | 54 | 54 |

| Objective | | | | | |
|---|---|---|---|---|---|

**Notes - 2002**

The 2002 indicator is based on the State estimates from SLAITS.

This measure is the percent of CSHCN in the State age 0 to 18 years who receive coordinated, ongoing, comprehensive care within a medical home.
Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2001.

**Notes - 2003**

The data reported in 2002 have pre-populated the data for 2003 for this performance measure and is based on the State estimates from SLAITS.

This measure is the percent of CSHCN in the State age 0 to 18 years who receive coordinated, ongoing, comprehensive care within a medical home.
Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2001.

**Notes - 2004**

The data reported in 2002 have pre-populated the data for 2004 for this performance measure and is based on the State estimates from SLAITS.

This measure is the percent of CSHCN in the State age 0 to 18 years who receive coordinated, ongoing, comprehensive care within a medical home.
Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2001.

## a. Last Year's Accomplishments

NPM 03 is from the National CSHCN Survey. Based on this survey, 44.7 percent of the CSHCN in California receive coordinated, ongoing, comprehensive care within a medical home. Last year's accomplishments related to this measure included:

1) The CMS Branch has been collaborating with the California Medical Home Project; the CA Medical Home Project grant ended Dec. 31, 2004, but the website is being maintained for resource materials.

2) Children's Hospital LA (CHLA) applied for and received a grant from HRSA for Improving Access to Care for Children and Youth with Epilepsy in CA; CCS will be a collaborative partner.

3) The CMS Branch has established a performance measure to evaluate whether CMS programs provide effective case management to eligible children. Within this measure is an assessment of whether children in the CCS program have a documented medical home. County CCS programs have been evaluating this over the past year.

4) CCS collaborated with a conference in S. California in May 2004 on "Building Service Systems for CSHCN" sponsored in part by UCLA and the CA Medical Home Project addressing agency roles regarding the medical home.

5) LA Care and Healthnet MCMC plans partnered with LA County CCS to make a change to the web-based system so that primary care providers receive copies of all authorizations for the CCS eligible child in their practice.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. CCS is collaborating with Children's Hospital Los Angeles for a HRSA grant to improve access to care for children and youth with epilepsy. | | X | | |
| 2. CCS counties are evaluating their programs for documentation of medical home for each client . | | | | X |
| 3. CCS is assisting with medical home training for the Infant Development Association. | | | | X |
| 4. CCS is re-initiating work on a program policy letter for medical home for CCS clients. | | | | X |
| 5. CCS is collaborating with Parents Helping Parents on workshops for constructing a family medical home notebook. | | X | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

CCS is collaborating with CHLA and the CA Epilepsy Foundation on a grant from HRSA for Improving Access to Care for Children and Youth with Epilepsy in CA; the overall goal of the proposed project is to improve access to health and other services and supports related to epilepsy by facilitating the development of state-wide community-based interagency models of comprehensive, family-centered, culturally-effective care and state-wide standards of care in an effort to achieve early detection, diagnosis and best-practices treatment for children and youth (0-18) with epilepsy in CA, especially those residing in medically underserved areas, as well as to eradicate the often-associated stigma through increasing public awareness and understanding of the disorder.

Other activities include:

1) County CCS programs are assessing whether CCS eligible children have a documented medical home and looking at ways to improve this.

2) Santa Clara CCS is collaborating with Parents Helping Parents on construction of a family medical home notebook that will be available in English, Spanish, and Mandarin.

3) CCS assisted with a medical home training for the statewide Infant Development Association Meeting in LA in April 2005.

## c. Plan for the Coming Year

Plans for the coming year include:

1) Collaboration with CHLA on the grant from HRSA for Improving Access to Care for Children and Youth with Epilepsy in CA as described in "Current Activities".

2) Re-initiate work on a policy letter for CCS regarding the medical home for CCS clients, particularly authorization of the medical home and ramifications of this authorization.

3) Continued evaluation by county CCS programs of whether children in the CCS program have a medical home and how to improve on this part of a performance measure regarding effective case management.

4) Kern County CCS in partnership with the managed care plans in Kern County is planning a seminar on provider outreach and education about CCS and medical homes.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | 60.5 | 62.5 |
| Annual Indicator | | | 59.3 | 59.3 | 59.3 |
| Numerator | | | | | |
| Denominator | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 64.5 | 66.5 | 68.5 | 70.5 | 70.5 |

**Notes - 2002**

The 2002 indicator is based on the State estimates from SLAITS.

This measure is the percent of CSHCN age 0 to 18 years whose families have adequate private and/or public insurance to pay for the services they need.
Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2001.

**Notes - 2003**

The 2003 indicator is pre-populated from 2002 and is based on the State estimates from SLAITS.

This measure is the percent of CSHCN age 0 to 18 years whose families have adequate private and/or public insurance to pay for the services they need.
Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with

Special Health Care Needs, 2001.

**Notes - 2004**

The 2004 indicator is pre-populated from 2002 and is based on the State estimates from SLAITS.

This measure is the percent of CSHCN age 0 to 18 years whose families have adequate private and/or public insurance to pay for the services they need.
Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2001.

## a. Last Year's Accomplishments

NPM 04 is from the CSHCN Survey and is related to population-based services. For the survey period, October 2000 to April 2002, 59.3 percent of families of CSHCN age 0 to 18 years in California had adequate private and/or public insurance to pay for the services they needed.

CMS activities to increase third party coverage for children have primarily revolved around implementation of the CHDP Gateway. Prior to the Gateway, approximately 1.1 million children receiving CHDP services were not enrolled in Medi-Cal or HF although it was estimated that approximately 760,000 children receiving CHDP services were eligible for comprehensive coverage through Medi-Cal or HF. Children enrolled in CHDP, who are identified with CCS eligible conditions (CSHCN), have access to Medi-Cal or HF coverage through the CHDP Gateway.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Work continues on a CMS web-based system with connectivity to DHS' Other Health Coverage file. | | X | | |
| 2. There is post implementation of modified pre-enrollment Gateway process for infants. | | X | | |
| 3. There are liaison activities with Healthy Families to facilitate AIM (Access for Infants and Mothers) transitioning for babies . | | X | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

One component of the CCS web-based system activated on July 1, 2004, is connectivity to DHS' Other Health Coverage (OHC) file. This enables the CMS Branch to determine whether CCS eligible children have access to private health coverage. When the CMS Branch learns that a child has coverage not shown on the OHC file, it can add this information to the file.

DHS has modified the pre-enrollment process to allow the Gateway transaction to identify and "deem" certain infants under one year of age as eligible for ongoing, full-scope, no cost Medi-

Cal at the time of a CHDP Health Assessment.

The CMS Branch is working with HF and the AIM program to facilitate enrollment of eligible infants into HF and those with CCS eligible conditions into the CCS program.

### c. Plan for the Coming Year

The CMS Branch will continue to work with HF and the AIM program to facilitate enrollment of eligible infants into HF and those with CCS eligible conditions into the CCS program. The Branch will continue to update the DHS' OHC file as health coverage information is obtained. The Branch will continue to implement the CHDP Gateway and identify CCS eligible children through the Gateway process.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | 67 | 68 |
| Annual Indicator | | | 65.9 | 65.9 | 65.9 |
| Numerator | | | | | |
| Denominator | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 69 | 70 | 71 | 72 | 72 |

**Notes - 2002**

The 2002 indicator is based on the State estimates from SLAITS.

This measure is the percent of CSHCN age 0 to 18 years whose families report the community-based service systems are organized so they can use them easily.
Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2001.

**Notes - 2003**

The 2003 indicator is pre-populated from 2002 and is based on the State estimates from SLAITS.

This measure is the percent of CSHCN age 0 to 18 years whose families report the community-

based service systems are organized so they can use them easily.
Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2001.

**Notes - 2004**

The 2004 indicator is pre-populated from 2002 and is based on the State estimates from SLAITS.

This measure is the percent of CSHCN age 0 to 18 years whose families report the community-based service systems are organized so they can use them easily.
Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2001.

## a. Last Year's Accomplishments

NPM 05 is a National CSHCN Survey measure and is the percent of CSHCN age 0 to 18 years whose families report that community-based service systems are organized so they can use them easily. For California, this result was 65.9 percent.

The CMS Branch is developing policy to instruct counties on methods to collaborate with families and community organizations in the provision of services and assisting CCS approved hospitals and Special Care Centers (SCCs) with implementation of family-centered care (FCC). The CMS Branch continues collaboration with Family Voices, parent representatives, and diverse parent groups through the Interagency Coordinating Council for Early Start. In addition, the CCS program has continued to facilitate FCC services for CSHCN and their families when needed through reimbursing for lodging, meals, and travel for SCC visits and hospitalizations and making medical appointments including clustering appointments on one to two days.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. CMS is reviewing CCS-approved hospitals, neonatal intensive care units, pediatric intensive care units, and special care centers for implementation of family-centered care (FCC). | | | | X |
| 2. Family members are participating on CCS advisory committees and task forces. | | | | X |
| 3. CHDP, HCPCFC, and CCS programs are evaluating effectiveness of their case management through a performance measure. | | | | X |
| 4. CCS is participating on HRSA grant for improving access to care for children and youth with epilepsy. | | X | | |
| 5. CCS is collaborating through CRISS with Family Voices and USC/CHLA for MCHB grant to implement integrated community based systems of care for CSHCN. | | X | | |
| 6. CMS is collaborating with Family Voices, parent representatives, parent groups through Interagency Coordinating Council for Early Start. | | | | X |
| 7. CMS Branch is evaluating collaborative relationships with other agencies, departments, and organizations. | | | | X |
| 8. CRISS FCC Workgroup meets bimonthly and reports are shared on | | | | |

| | | | | |
|---|---|---|---|---|
| FCC activities and resources; FCC trainings and conferences are planned. | | | | X |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

Current activities include:

1) Reviewing CCS-approved hospitals, Neonatal Intensive Care Units (NICUs), Pediatric Intensive Care Units (PICUs), and SCCs for implementation of FCC.

2) Family members are participating on CCS advisory committees and task forces.

3) CHDP, HCPCFC, and CCS programs are reporting on a performance measure demonstrating that they provide effective case management.

4) Counties are sending out family satisfaction surveys.

5) Family members of CSHCN are participating in in-service training for CCS staff in order to provide the family perspective of the CCS program.

6) CCS is collaborating with CHLA and the CA Epilepsy Foundation on a grant from HRSA for Improving Access to Care for Children and Youth with Epilepsy in CA; the overall goal of the project is to improve access to health and other services and supports related to epilepsy by facilitating the development of state-wide community-based interagency models of comprehensive, family-centered, culturally-effective care and state-wide standards of care.

7) A federal MCHB grant has been awarded officially to the University Affiliated Program at USC/Children's Hospital LA for collaboration with CRISS and Family Voices of California for a 3-year project to implement integrated community systems of care for CSHCN; activities to promote systems of care for CSHCN will be expanded in the 14 CCS County region (involved with CRISS) and in Los Angeles.

8) Work is beginning on the Champions for Progress Center Incentive Award for FFY 2004-05 to further the development and implementation of a community-based system of care for CSHCN and their families.

9) The LA Partnership for Special needs Children, a CCS stakeholder group, has been focusing on increasing awareness of the need to screen and when appropriate to refer CCS eligible children for mental health problems.

## c. Plan for the Coming Year

Plans for the coming year include:

1) Family members will continue participating on CCS advisory committees and task forces.

2) CHDP, HCPCFC, and CCS programs will continue reporting on a performance measure demonstrating that they provide effective case management; results will be compared with future years.

3) The CMS Branch is evaluating collaborative relationships with other departments, agencies, and organizations.

4) The FCC Work Group will continue meeting bimonthly, and county member representatives will report on their FCC activities, share ideas and resources, and coordinate conferences, trainings and activities.

5) Counties will continue to develop family satisfaction surveys.

6) More counties will involve families of CSHCN in in-service training of CCS staff to provide staff with the family perspective of the CCS program.

7) CCS will be collaborating with CHLA and the CA Epilepsy Foundation on the HRSA grant identified in "Current Activities".

8) Work will continue on the Federal MCHB grant for a 3-year project to implement integrated community systems of care for CSHCN as noted in "Current Activities".

9) Work will continue on the Champions for Progress Center Incentive Award for FFY 2004-05 to further the development and implementation of a community-based system of care for CSHCN and their families.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | | |
| Annual Indicator | | | 5.8 | 5.8 | 5.8 |
| Numerator | | | | | |
| Denominator | | | | | |
| Is the Data Provisional or Final? | | | | Final | |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | | | | | |

**Notes - 2002**

This measure is the percent of youth with special health care needs in the country who receive the services necessary to make transitions to all aspects of adult life.
Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2001.
Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the

2002 indicator is the national average except for Maine which has its State value noted.

**Notes - 2003**

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

This measure is the percent of youth with special health care needs in the country who receive the services necessary to make transitions to all aspects of adult life.
Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2001.
Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator is the national average except for Maine which has its State value noted.

**Notes - 2004**

The data reported in 2002 have pre-populated the data for 2004 for this performance measure.

This measure is the percent of youth with special health care needs in the country who receive the services necessary to make transitions to all aspects of adult life.
Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2001.
Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator is the national average except for Maine which has its State value noted.

## a. Last Year's Accomplishments

NPM 06 is a National CSHCN Survey measure and is the percentage of youth who received the services necessary to make transitions to all aspects of adult life. Due to small sample sizes, the relative standard error for every state except Maine was greater than 30 percent, so the national average is reported, which is 5.8 percent.

A few county CCS programs in California have been aggressively tackling transitional services for CSHCN, but most counties need to develop and implement plans of action. Within the past year, the CMS Branch has formed a State Transition Workgroup (see Current Activities for details).

There have also been transition-planning activities in Southern California. Seven county CCS programs are ensuring at a minimum that all identified needs, supplies, surgeries, and insurance eligibility are addressed before the age of 21. MTP staff in Ventura County regularly attend and participate with the Special Education Local Planning Areas (SELPA) Interagency Coordinating Transition Council, and there is coordinated SELPA training on the process of transitioning to adulthood. In Kern County, the MTP Physiatry Clinic emphasizes referral for transitioning services for older children who have sustained spinal cord injuries, traumatic brain injuries, vascular accidents and related disabilities. In Santa Barbara County, a Transition Committee of CCS staff receives input from CCS parents, young adult clients, and the Family Support Center to assess and develop ways to infuse the concept of transition into all CCS services and functions. The committee organizes in-service training and presentations for CCS staff. Current and former CCS clients attend meetings to share their experiences.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. CMS Branch has formed a Transition Work Group to ultimately | | | | X |

| | | | | |
|---|---|---|---|---|
| develop transition policy and guidelines statewide for adolescents. | | | | |
| 2. At FCC Workgroup meetings CCS programs report on transition activities and matrix of activities is maintained. | | | | X |
| 3. CCS programs have transition committees, clinics, and workshops. | | | | X |
| 4. CMS staff work with SCCs to integrate transition planning into patient care. | | X | | |
| 5. CCS social work consultants meet on transition issues. | | X | | |
| 6. CMS is contracting with CRISS to receive statewide data on CCS program transition activities. | | X | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

Current activities include:

1) The CMS Branch newly formed Transition Work Group which will eventually develop written policy and guidelines for transition planning for adolescents, has begun to review other models around the country, consider areas of transition for focus, look at resources, review the status of the CCS program at this time. The group includes county CCS physicians, nurses (one of whom is also a parent of a child with special needs), social workers, and therapists; a physician from a MCMC plan; a community advocate; two physicians from UCLA with interest and expertise in transitional care; a representative from the Healthy and Ready to Work Program; several parents (including the Parent Liaison from LA County CCS); and a young adult who is transitioning out of CCS.

2) At the bimonthly meetings of the Family-Centered Care (FCC) Work Group, county CCS programs report on transition activities. A matrix of transition activities of each of the 14 counties represented is maintained and updated.

3) CCS social work consultants have quarterly meetings and discuss transition issues.

4) Some county CCS programs have transition committees, clinics and workshops.

5) State CCS staff instruct CCS-approved SCCs and those newly applying for approval on the importance and methods of integrating transition planning into patient care beginning at age 14 years.

## c. Plan for the Coming Year

Plans for the coming year include:

1) The Transition Work Group will continue meeting approximately quarterly, preparing for eventually developing written policy and guidelines for transition planning for adolescents.

2) The FCC Work Group will continue to monitor transition activities in the 14 CRISS counties.

3) CCS social work consultants will continue to meet on transition issues.

4) More counties will become involved in planning and implementing transition strategies.

5) State CCS staff will continue to instruct CCS-approved SCCs and those newly applying for approval on the importance and methods of integrating transition planning into patient care beginning at age 14 years.

6) The CMS Branch will be receiving data and analyzed data regarding statewide CCS program transition activities.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 76 | 76.4 | 75.4 | 75.8 | 75.8 |
| Annual Indicator | 75.3 | 74.9 | 75.8 | 77.4 | 77.4 |
| Numerator | 419794 | 419944 | 427631 | 400715 | |
| Denominator | 557496 | 560673 | 564157 | 517719 | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 78 | 78.3 | 78.6 | 78.9 | 79.2 |

**Notes - 2002**

Source of percent immunized: National Immunization Survey: 2002 data source on the web at: http://www.cdc.gov/nip/coverage/NIS/01/tab3_antigen_state.xls.
Data for the 4:3:1:3 series used.
Denominator: The number of two-year olds in the given year from the Department of Finance figures, Race/Ethnic Population with Age and Sex Detail, 1970-2040. Sacramento, California, December, 1998. http://www.dof.ca.gov/html/Demograp/Race.htm.
Numerators are estimates "derived" by multiplying the percent (4:3:1:3) of immunized children by the denominator.

**Notes - 2003**

Source of percent immunized: National Immunization Survey: 2003 data source on the web at the URL: http://www.cdc.gov/nip/coverage/NIS/03/tab02_antigen_iap.xls. Data for the 4:3:1:3:3 series used.
Denominator: The number of two-year olds in the given year is from the Department of Finance figures, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, May 2004. http://www.dof.ca.gov/html/Demograp/DRU_datafiles/Race/RaceData_2000-2050/California.txt
Numerators are estimates "derived" by multiplying the percent of immunized children by the

denominator.
Note: This is a new data source and comparisons should not be made with data from previous years. Data for 2000-2002 reported based upon 4:3:1:3 immunization scehdule.

**Notes - 2004**

A manual indicator is reported for 2004 based on 2003.

## a. Last Year's Accomplishments

NPM 07, the percentage of 19 to 35 month olds in California who completed the full schedule of age-appropriate immunizations, was 77.4 percent in 2003. The Healthy People 2010 objective is 80 percent. (The standard for calculating age-appropriate immunizations changed this year from the 4-3-1-3 schedule used in previous years to the 4-3-1-3-3 schedule. The 2003 data point is therefore not comparable to the data reported for previous years. The annual objective was also based on the previous standard and is no longer applicable.)

The 4-3-1-3-3 schedule consists of four or more doses of diphtheria and tetanus toxoids and pertussis vaccine/diphtheria and tetanus toxoid (DPT/DT); three or more doses of poliovirus vaccine; one or more doses of measles-containing vaccine (MCV); three or more doses of Haemophilus influenza type b vaccine (Hib); and three or more doses of Hepatitis B vaccine (Hep B).

To promote childhood immunization, the CHDP program assures access to vaccines that are required for school entry and has issued provider information notices that contain updated information on the vaccines covered by the CHDP program. CHDP also maintains access to vaccines that are indicated in some high risk children, reimbursing medical providers for vaccine purchase when these vaccines are not supplied by the federal Vaccines for Children (VFC) program.

Efforts to improve immunization rates have been made through CHDP, Medi-Cal, Healthy Families, Healthy Start, the Health Insurance Plan of California (HIPC), the Access for Infants and Mothers Program (AIM), and the Immunization (IZ) Branch of DHS.

The CMS Branch collaborated with the IZ Branch on informing providers of the Pneumococcal Conjugate Vaccine shortage and the CDC recommendation to suspend third and fourth doses for healthy children. For VFC-eligible children who were in contact with high-risk groups, CHDP followed the recommendation of the National Advisory Committee on Immunization Practices (ACIP) to provide influenza vaccinations to siblings and household contacts of high-risk groups, including healthy infants age 6-24 months.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. The MCAH/OFP and CMS Branches advocate for eligible children to join Medi-Cal or HF, both of which cover immunization. | | X | | |
| 2. Healthy Start (HS), the Health Insurance Plan of California (HIPC), and Access for Infants and Mothers (AIM) provide health care access, including immunizations, for children. | | X | | |
| 3. Health promotion for adequate immunizations is also done through the CHDP Gateway and the BIH program, AFLP, ASPPP, and CPSP. | | | X | |
| 4. Nine regional immunization registries, covering about 85 percent of the state’s population, exchange immunization data. | | | | X |

| | | | | |
|---|---|---|---|---|
| 5. Based on data from the regional immunization registries, pockets of need are identified, and interventions are developed. | | | | X |
| 6. The CMS and Immunization (IZ) Branches are informing providers of the current Pneumococcal Conjugate Vaccine shortage and the CDC recommendation to suspend third and fourth doses for healthy children. | | X | | |
| 7. The CMS and IZ Branches are working on providing the Tdap (Boostrix Trademark) Vaccine as a VFC (Vaccines for Children) vaccine for 10-18-year-old children and youth. | | | X | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

The CMS Branch and Medi-Cal are encouraging providers to deliver needed services, particularly immunizations, during the CHDP Gateway / pre-enrollment period.

The MCAH/OFP and CMS Branches continue advocating for families to enroll in Medi-Cal or HF. With more children having access to primary and preventive care, the number of children receiving immunizations should increase. Local MCAH/OFPprograms, including AFLP, ASPPP, and BIH, continue to assess the immunization status of adolescent clients and their children on a periodic schedule, and to promote the importance of maintaining up-to-date immunizations by assisting program clients to access ongoing preventive care.

California is working on improving regional immunization registries, creating a state hub to link all the regions, and unifying the statewide system for identifying pockets of need and developing adequate interventions. There are nine regional immunization registries, covering 40 California counties and reaching nearly 85 percent of the state's population. Efforts are underway to improve the electronic exchange of information on patients moving between regions and jurisdictions and also on allowing schools, childcare centers, Medi-Cal, WIC, and Cal-WORKS to link into regional registries.

The CMS and IZ Branches are collaborating on providing Tetanus and Diphtheria (Td) Toxoids Adsorbed for Adults Preservative Free as a VFC vaccine. The vaccine is provided at no charge by the VFC program for CHDP eligible children seven years and older. Work has also begun to allow Meningococcal Conjugate Vaccine (MCV4) as a VFC vaccine for administration to CHDP-eligible youth ages eleven years through eighteen years.

## c. Plan for the Coming Year

The CMS and IZ Branches will work together to make providers aware of vaccine shortages as they occur and any other immunization-related communications that need to reach providers. Through the CMS Branch and the CHDP Executive Committee, local CHDP programs will be kept informed of all immunization issues.

The CMS and IZ Branches will be collaborating on Program and Provider letters for the Meningococcal Conjugate Vaccine and working in the coming months on providing the Tdap (Boostrix™) Vaccine as a VFC vaccine for 10 to 18 year old children and youth. The Tdap (Boostrix™) Vaccine - Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis -- was recently approved by the FDA for use with this age group.

The CMS Branch will continue to collaborate with the IZ Branch with its work on California's

statewide immunization registry.

The MCAH/OFP Branch is planning to work with the IZ Branch in its roll-out of the upcoming, new adolescent immunizations over the next couple years.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 28.7 | 25 | 23.5 | 22.3 | 21.9 |
| Annual Indicator | 26.6 | 23.8 | 22.4 | 21.1 | 21.1 |
| Numerator | 18887 | 17307 | 16660 | 16193 | |
| Denominator | 711170 | 726912 | 745239 | 766755 | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 20 | 19.8 | 19.7 | 19.6 | 19.5 |

**Notes - 2002**

Numerator: State of California, Department of Health Services, Center for Health Statistics, 2002 California Birth Statistical Master File. Tabulations by place of residence.
Denominator: Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, May 2004.
http://www.dof.ca.gov/html/Demograp/DRU_datafiles/Race/RaceData_2000-2050/California.txt

**Notes - 2003**

Numerator: State of California, Department of Health Services, Center for Health Statistics, 2003 California Birth Statistical Master File. Tabulations by place of residence.
Denominator: Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, May 2004.
http://www.dof.ca.gov/html/Demograp/DRU_datafiles/Race/RaceData_2000-2050/California.txt.
Rates for the years 2000-2002 may have changed from those reported in last year's report because they have been recalculated based upon updated population projections from the California Department of Finance. The new projections are based on the 2000 Census while data from previous reports were based on population projections from the 1990 Census.

**Notes - 2004**

A manual indicator is reported for 2004 based on 2003.

a. Last Year's Accomplishments

Reducing the adolescent birth rate is one of California's highest health priorities. Between 1987 and 1994, the birth rate among 15-17 year olds increased from 34 to 45 births per 1,000

women. Since 1994, the rate has fallen steadily, down to 26.6 in 2000, and down further to 21.1 in 2003. The annual objective of 22.3 for 2003 was achieved. (Numbers for the years 2000-2002 have changed slightly from those in last year's report because they have been recalculated based on updated population projections from the California Department of Finance. The new projections are based on the 2000 Census; numbers in previous reports were based on population projected from the 1990 Census.)

A decrease in teen birth rates was observed among all racial/ethnic groups. However, racial and ethnic differences in the adolescent birth rate persist. In 2003, Asian adolescents had the lowest birth rate for women 15-17 years old (6.7 births per 1,000 women), followed by Whites (7.2). Hispanic women had an adolescent birth rate of 37.4 (five times higher than the rates for Asians and Whites), and African American women had a rate of 20.7.

The MCAH/OFP Branch supports several teen pregnancy prevention programs. The Adolescent Family Life Program (AFLP) utilizes a case management and mentoring model to assess and address the risks and resources of adolescent clients and their children related to pregnancy prevention, birth outcomes, child health and safety, access to health insurance, appropriate utilization of health care, and enhancing the psychosocial and economic well-being of the adolescent family.

The Adolescent Sibling Pregnancy Prevention Program (ASPPP) works with non-pregnant, non-parenting siblings of clients of the AFLP Program or the Cal-Learn Program. ASPPP is designed to promote adolescent health and development, educational achievement, positive relationships with family and peers, and prevent early and unplanned pregnancies among this high-risk population.

Office of Family Planning (OFP) programs include the Family Planning, Access, Care, and Treatment Program (Family PACT); the Teen Smart Outreach (TSO) Program; the Community Challenge Grant (CCG) Program; the Male Involvement Program (MIP); and the Information and Education Program (I&E).

In addition to the DHS teen pregnancy prevention programs, DSS operates the Cal Learn program, and CDE funds 140 school districts and county offices of education to operate the California School Age Families Education (Cal-SAFE) program. Cal Learn assists pregnant/parenting teens to attend and graduate from high school. Cal-SAFE is designed to increase the availability of support services necessary for enrolled expectant/parenting students to improve academic achievement and parenting skills.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. The AFLP and the ASPPP provide case management services to pregnant and/or parenting teens and their siblings to improve birth outcomes and prevent additional pregnancies. | | X | | |
| 2. The Family PACT Program provides comprehensive clinical contraceptive and reproductive health services for adolescents at more than 2,000 provider sites throughout California. | X | | | |
| 3. The Community Challenge Grant Program funds 117 community agencies and serves approximately 200,000 teens annually. | | X | | |
| 4. The Teen Smart Outreach program does outreach to teens and offers in-depth counseling related to sexual and contraceptive concerns of | | | | |

| | | | | |
|---|---|---|---|---|
| adolescents who access family planning services through the Family PACT program. | | X | | |
| 5. The Information and Education program provides community-based educational services on teen pregnancy prevention. | | | X | |
| 6. The Male Involvement Program provides community-based educational services which promote the involvement of young men in the prevention of teen pregnancy and unintended fatherhood. | | | X | |
| 7. The Cal-SAFE program, which operates in 140 school districts, promotes teen pregnancy prevention. | | | X | |
| 8. MCAH/OFP is working with other key stakeholders at the state level, including the Dept of Education and the STD Control Branch, to better coordinate efforts in HIV, STD, and teen pregnancy prevention. | | | X | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

AFLP and ASPPP provide case management services to pregnant and/or parenting teens and their siblings. AFLP provides services to about 17,000 teens a year, and the ASPPP to about 2,000 teens a year.

The Family PACT Program provides reproductive health services, education, and counseling to 300,000 adolescents annually, including comprehensive clinical exams and access to contraception. In particular, the Teen Smart Outreach Program offers in-depth reproductive health counseling to adolescent Family PACT clients. OFP contracts with the UCSF Center for Reproductive Health Research & Policy for Family PACT and TSO program monitoring and evaluation services. Family PACT undertakes ongoing efforts in the areas of client outreach; provider recruitment, training, and technical assistance; and the addition of new FDA-approved contraception methods to the benefits package.

CCG promotes community-based partnerships to develop effective local teen pregnancy prevention programs, to promote responsible parenting, and to involve the father in the economic, social, and emotional support of his children. CCG funds 117 community agencies and serves approximately 200,000 teens annually.

MIP promotes the involvement of young men in the prevention of teen pregnancy and unintended fatherhood. MIP funds 21 agencies and serves about 25,000 adolescent boys and young adult males annually. OFP Information and Education (I&E) projects operate in 27 community agencies and serve approximately 75,000 youth in grades 6 through 12 annually. I&E projects and Male Involvement Programs are currently developing strategies to increase access to Family PACT services.

MCAH/OFP is collaborating with CDE, the STD Control Branch, the Office of AIDS, and DSS in improving HIV/STD/teen pregnancy prevention integration. Representatives from the MCAH/OFP Branch, CDE, and the STD Control Branch have attended regional meetings with other states sponsored by the Society of State Directors of Health, Physical Education, and Recreation; AMCHP; National Alliance of State and Territorial AIDS Directors; the National Coalition of STD Directors; and the National Conference of State Legislatures. This work group conducted a jointly sponsored training on Cultural Competence and Youth Development within HIV education and sexual health education programs in June 2005.

California recently received a $1000 technical assistance grant to continue activities to better coordinate efforts in the prevention of STD, HIV, and teen pregnancy. Key stakeholders participating in this effort will include the MCAH/OFP Branch, STD Control Branch, Office of

AIDS and CDE.

## c. Plan for the Coming Year

In spite of the considerable success in the reduction of teen birth rates in recent years, teen pregnancy prevention will continue to be a major issue for California, given the demographics of California's youth population. Between 2003 and 2009, the teen population is projected to increase by 14 percent, and the Hispanic teen population (with the highest birth rates of any race/ethnic group) is projected to increase by 28 percent.

AFLP, ASPPP, Family PACT, TSO, CCG, MIP and I&E will continue their teen pregnancy prevention efforts. CCG, I&E and MIP Programs now require clinical services linkages, i.e., they must demonstrate formal referral mechanisms and collaboration with one or more Family PACT providers. They are currently working to develop and implement teen specific strategies to increase access to Family PACT services.

State staff and AFLP regional representatives are working on improvements in the measurement and reporting of program process and outcome indicators, including contraceptive use and repeat birth rates. In an effort to facilitate continuous quality improvement, new routine reports on process and outcome indicators will be made available in the coming year. The reports are designed to be easily accessible to local AFLP agencies.

The Integrative Approaches to Adolescent Sexual Health Work Group will be discussing with our leadership in DHS and CDE the ability to continue collaborative meetings and to continue to work toward common goals and collaborative projects.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 19.6 | 18.7 | 19.5 | 19.9 | 20.2 |
| Annual Indicator | 18.7 | 19.5 | 19.7 | 31.0 | 31.0 |
| Numerator | 226236 | 230919 | 230010 | 157000 | 157000 |
| Denominator | 1211762 | 1184201 | 1167565 | 506000 | 506000 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 31 | 31 | 31 | 31 | 31 |

**Notes - 2002**

Source: The dental sealant percentage is an unweighted average calculated by the Maternal and Child Health Branch. The data are from the California Department of Health Services, Medical Care Statistics Section: data for eligibles (denominator) and recipients (ages 7 through 8) who received a sealant on at least one permanent tooth during the calendar year 2002 (numerator). Delta Dental Plan of California provided data on the percentage of enrollees ages 7 through 8 who received a sealant on at least one permanent tooth during the calendar year 2002. The numerators are estimates derived by multiplying the percent by the denominator. Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 1970-2040. Sacramento, California. December 1998. http://www.dof.ca.gov/html/Demograp/Race.htm. (Estimated population of relevant child age group)

**Notes - 2003**

Numerator: Based on unweighted, interim results from a not-yet-completed survey of a representative sample of elementary schools in California, 2005. Dental sealant information is based on a one-minute, non-invasive oral health screening of all third graders in selected schools using protocols from the Association of State and Territorial Dental Directors. Denominator: CA Department of Finance projection of 8-year olds in 2005, multiplied by the preliminary percentage of 3rd graders with identified dental sealants as determined by the 2005 Oral Health Needs Assessment of Children (OHNA).
Note: This is a new data source and comparisons should not be made with data from previous years.

**Notes - 2004**

Numerator: Based on unweighted, interim results from a not-yet-completed survey of a representative sample of elementary schools in California, 2005. Dental sealant information is based on a one-minute, non-invasive oral health screening of all third graders in selected schools using protocols from the Association of State and Territorial Dental Directors. Denominator: CA Department of Finance projection of 8-year olds in 2005, multiplied by the preliminary percentage of 3rd graders with identified dental sealants as determined by the 2005 Oral Health Needs Assessment of Children (OHNA).
Note: This is a new data source and comparisons should not be made with data from 2002 or earlier.

## a. Last Year's Accomplishments

Children's access to preventive dental services is assessed in relation to the percent of third grade children who have received protective sealants on at least one permanent molar tooth. The percent with sealant in California is estimated to be 31 percent. The Healthy People 2010 objective is 50 percent. (The source of data for this performance measure has changed since last year, and no comparable data for previous years are available. The annual objective of 19.9 percent for 2003 was also based on the previous data source and is no longer applicable.)

The current source of data for NPM 09 is the 2005 Oral Health Needs Assessment for Children (OHNA), a survey of a representative sample of elementary school children in California. The percentage of children with sealants presented here is a simple unweighted average of the sample data collected to this point and may differ from the final weighted estimate using all the data.

MCAH/OFP, CMS, and OOH are members of the California Oral Health Access Initiative (OHAI). The OHAI Council is a diverse panel of oral health stakeholders that are working together to improve the oral health status of the state's traditionally underserved populations. The Dental Health Foundation (DHF) and the California Primary Care Association (CPCA) serve as co-facilitators of OHAI. The initiative is funded by the California Wellness Foundation and the WK Kellog Foundation.

MCAH/OFP, CMS, and OOH are also members of the DHS Task Force on Oral Health, along with Denti-Cal, WIC, the California Managed Risk Medical Insurance Board (MRMIB), the Prop 10 Commission, the California Dental Association, the Dental Health Foundation, UCSF and Delta Dental. The Task Force assists in the coordination of state oral health activities and serves as a clearinghouse for member organizations.

The State First Five Commission has listed oral health as one of its five priorities. The First Five Oral Health Initiative consists of 1) a $7 million Early Childhood Oral Health Education and Training Project, and 2) a $3 million Oral Health Demonstration Project. Training for providers started in 2004 and will last for the four years of the grant. Several counties have also allocated First Five funds for services related to oral health.

Medi-Cal and Healthy Families (HF) provide access to a comprehensive package of primary and preventive services, including dental care, for California's low-income children. CHDP provides dental screenings for over 1.7 million children a year. Also, through the CHDP Gateway, providers are helping to get pre-enrolled children into dental services.

The Dental Subcommittee of the CHDP Executive Committee revised the CHDP Dental Periodicity Schedule to recommend dental referrals beginning at one year of age. The CHDP program has also developed a training packet for CHDP providers that contains instruction on performing dental examinations on young children.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Medi-Cal and HF provide access to a comprehensive package of primary and preventive services, including dental care, for California's low-income children. | | X | | |
| 2. CHDP provides dental screening for children up to 21 years of age. | | X | | |
| 3. The CMS Branch is undertaking activities to encourage orthodontists and dentists to accept more CCS children into their practices, including more rapid reimbursement. | | X | | |
| 4. WIC and MCAH/OFP provide toothbrushes and toothpaste to program participants. | | X | | |
| 5. The Office of Oral Health (OOH) and MCAH/OFP Branches are working with the CA Dental Health Foundation to conduct a statewide Oral Health Needs Assessment. | X | | | |
| 6. MCAH/OFP is contracting with UCSF for an oral health epidemiologist and a dental hygienist to serve as MCAH/OFP Oral Health Policy Consultants to meet the growing demand for technical assistance at both the state and local levels. | | | | X |
| 7. The CA Children's Dental Disease Prevention Program (CDDPP), under the OOH, serves more than 300,000 school children annually, including dental sealants screening/application and oral health education in the classroom. | | X | | |
| 8. CDDPP includes a parent education component, which provides training to the parents of children in the OOH's school-based program about oral disease prevention strategies and the importance of nutrition to health, including oral health. | | X | | |
| | | | | |

| | | | | |
|---|---|---|---|---|
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

The DHS Office of Oral Health (OOH) contracts with the UCSF School of Dentistry to oversee the California Children's Dental Disease Prevention Program (CDDPP), which serves more than 300,000 preschool and elementary school children annually. The CDDPP includes the screening/application of dental sealants to children in grades 2-5 as well as other activities such as oral health education in the classroom, fluoride supplements/mouth rinse and plaque control. A parent education component provides training to the parents of children in OOH's school-based program about oral disease prevention strategies and the importance of nutrition to health, including oral health.

OOH is partnering with the MCAH/OFP Branch and the Dental Health Foundation to conduct a statewide Oral Health Needs Assessment (OHNA) funded by the Health Resources and Services Administration (HRSA) and the California Dental Association Foundation. This statewide oral health surveillance project utilizes the Association of State and Territorial Dental Directors' screening materials. The assessment includes the presence of dental cavities among children in kindergarten and 3rd grade and a determination of whether sealants are present on 3rd graders.

Oral health educational materials, a brochure and poster in English and Spanish, entitled "Stop the Spread of Tooth Decay," were printed in 2004 and were distributed in 2004 and 2005 to MCH, CMS and Women, Infants & Children (WIC) Supplemental Nutrition Branch programs. These materials continue to be distributed upon request to various MCAH programs. Toothbrushes and children's fluoride toothpaste have also been distributed to local MCAH programs including AFLP, Black Infant Health (BIH), and CPSP as incentives and education tools as well as to domestic violence shelters.

Increased enrollment in HF and Medi-Cal is expected to contribute to increased access to preventive dental services. However, a significant impediment to increased access is the limited number of dentists who will accept children with Medi-Cal.

The CMS Branch continues various activities to encourage orthodontists and dentists to accept more CCS children into their orthodontic and dental practices. The CCS program is undertaking efforts that will (1) reduce turnaround time on provider reimbursement for dental/orthodontic services, (2) preserve and expand the dental/orthodontic provider network, (3) decrease the length of time for a CCS client to get an orthodontic screening, and (4) increase access to dental/orthodontic care for CCS clients.

## c. Plan for the Coming Year

State and county programs will continue to promote oral health, but the State will not be able to fully address NPM 09 until appropriate funds are allocated for sealant promotion, placement, and continuous surveillance of prevalence.

In order to meet the growing demand for technical assistance on oral health issues at both the state and local levels, the MCAH/OFP Branch contracted with University of California San Francisco (UCSF) for a licensed dentist to serve as the MCH Oral Health Policy Consultant. This contract expired June 30, 2004. The scope of work has been revised to include two staff, an oral health epidemiologist and a dental hygienist. The contract is currently awaiting state approval, after which time UCSF will fill these positions.

The MCAH/OFP Branch, in collaboration with UCSF, will be analyzing two years of data regarding oral health behavior during pregnancy. The questions are part of the Maternal and

Infant Health Assessment (MIHA) Survey. Data analysis is scheduled to be completed in late 2005.

MCAH/OFP, CMS, and OOH will continue their work with the California Oral Health Access Initiative and the DHS Task Force on Oral Health.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 2.7 | 2.6 | 2.8 | 2.6 | 2.6 |
| Annual Indicator | 2.9 | 3.1 | 2.9 | 3.6 | 3.6 |
| Numerator | 228 | 245 | 227 | 289 | |
| Denominator | 7792472 | 7856359 | 7905059 | 7960784 | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 2.9 | 2.9 | 2.9 | 2.9 | 2.9 |

**Notes - 2002**

Source: Numerators: State of California, Department of Health Services, Center for Health Statistics, 2002 California Death Statistical Master File. "Selected Injury-Related Sections of ICD-10" as modified by the National Center for Health Statistics, Centers for Disease Control And Injury Prevention and Epidemiology and the Prevention for Injury Control (EPIC) Branch, California Department of Health Services. Tabulations (by place of residence) were done by the MCAH/OFP Branch.
Denominator: Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, May 2004.
http://www.dof.ca.gov/html/Demograp/DRU_datafiles/Race/RaceData_2000-2050/California.txt

**Notes - 2003**

Source: Numerators: State of California, Department of Health Services, Center for Health Statistics, 2003 California Death Statistical Master File. "Selected Injury-Related Sections of ICD-10" as modified by the National Center for Health Statistics, Centers for Disease Control And Prevention and Epidemiology and the Prevention for Injury Control (EPIC) Branch, California Department of Health Services. Tabulations (by place of residence) were done by the MCAH/OFP Branch.
Denominator: Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, May 2004.
http://www.dof.ca.gov/html/Demograp/DRU_datafiles/Race/RaceData_2000-2050/California.txt.
Rates for the years 2000-2002 may have changed from those reported in last year's report

because they have been recalculated based upon updated population projections from the California Department of Finance. The new projections are based on the 2000 Census while data from previous reports were based on population projections from the 1990 Census.

**Notes - 2004**

A manual indicator is reported for 2004 based on 2003.

## a. Last Year's Accomplishments

California motor vehicle death rates for children aged 0-14 declined from 5.4 deaths per 100,000 in 1990 to 2.9 in 2000. Between 2000 and 2002, the rate was relatively stable, fluctuating between 2.9 and 3.1. The 2003 rate jumped to 3.6 (a total of 289 deaths), and the annual objective of 2.6 was not met. (Denominators are based on the number of adolescents, not the number of miles driven. Rates for the years 2000-2002 have changed slightly from those in last year's report because they have been recalculated based on updated population projections from the California Department of Finance. The new projections are based on the 2000 Census; numbers in previous reports were based on population projected from the 1990 Census.)

There are some differences by race/ethnicity for motor vehicle death rates among children (2003). The rate is highest for Hispanics at 4.1 per 100,000, followed by 3.7 for Whites, 3.2 for African-Americans, and 2.1 for Asians.

Some of the activities in California which have been undertaken to reduce motor vehicle death rates among children include: Increased enforcement of drinking and driving laws; passenger restraint laws; graduated driver licensing; public education campaigns addressing the risks of drinking while driving; and vehicle safety improvements.

The Center for Injury Prevention Policy and Practice (CIPPP) at San Diego State University serves as a resource center on child and adolescent injury prevention and provides technical assistance in the development, implementation and evaluation of injury prevention programs. CIPPP works with the MCAH/OFP Branch to organize the annual childhood injury prevention conference. CIPPP also produces Safety Literature updates with weekly references of current injury prevention articles.

The MCAH/OFP Branch funds local childhood injury prevention programs in five counties in three-year cycles. In 2002, CIPPP, in collaboration with the MCAH/OFP Branch, started a bi-monthly injury prevention teleconference with injury prevention professionals in the five counties funded at that time; regular teleconferencing enables statewide networking, joint planning, and skill development. This group then expanded to include other interested MCAH/OFP programs and stakeholders. In addition, an injury prevention list serve was started with the five funded programs and expanded to include a total of 23 MCAH jurisdictions. The list serve is used to give updates, alert programs of funding sources, and share information.

Other local MCAH programs have also undertaken motor vehicle injury prevention activities. Shasta County has been involved in a campaign working with teens on driving smart, driving sober, and the effects of riding with someone who is under the influence. Sonoma County has a program to work with youth around the provisions of graduated driver licensing.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. The MCAH/OFP Branch funds local childhood injury prevention programs in five local health jurisdictions in three-year cycles. | | | X | |

| | | | | |
|---|---|---|---|---|
| 2. The Center for Injury Prevention Policy and Practice (CIPPP) at San Diego State University provides data and technical assistance in the development, implementation and evaluation of injury prevention programs. | | | | X |
| 3. MCAH/OFP and CIPPP organize an annual childhood injury prevention conference. | | | | X |
| 4. CIPPP creates linkages between agencies, researchers, and advocates. | | | | X |
| 5. To raise funds to support child injury and abuse prevention programs, the State sells special car license plates, called Kid's Plates. | | X | | |
| 6. The Epidemiology and Prevention for Injury Control (EPIC) Branch maintains an up-to-date statewide list of current locally operated child passenger safety seat programs for use by traffic courts, community agencies, hospitals and clinics. | | X | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The MCAH/OFP Branch funds local childhood injury prevention programs in five counties in three-year cycles. Plumas, Siskiyou, Sacramento, Stanislaus, and Ventura Counties began receiving funding for three years beginning in July 2004. Other local MCAH programs are also undertaking motor venicle injury prevention activities, including participating in the SAFE KIDS Coalitions, child passenger safety checks, child passenger safety seat distribution, and bicycle helmet education programs.

California's Vehicle Occupant Safety Program (VOSP) works to prevent unnecessary death and disability to California's children by helping to strengthen and expand California's child passenger safety infrastructure. VOSP promotes resource sharing and capacity building among California's state and local Child Passenger Safety agencies and provides professional development opportunities, technical assistance and training resources. An updated statewide list of current locally operated child passenger safety seat programs for use by traffic courts, community agencies, hospitals and clinics is available online at http://www.dhs.ca.gov/ps/cdic/epic.

To raise funds to support child injury and abuse prevention programs, the State sells personalized auto license plates, called "Kid's Plates". Kid's Plates feature a heart, hand, star, or plus sign. The proceeds fund child injury prevention efforts, including bicycle safety, motor vehicle occupant protection, and pedestrian safety, as well as other child injury and abuse prevention programs. The Kid's Plates Program provides a wide range of technical assistance to help foster effective regional and local injury prevention efforts and funds grants for training and equipment. Between 1998 and 2003, over 200 grants were awarded to community-based organizations, local health departments, and other organizations. CIPPP is the Kid's Plate program administrator for the EPIC Branch.

The 18th annual Childhood Injury Prevention Conference was held in September 2004 in San Francisco. It provided the latest information on practices and research in injury prevention and in-depth training in specific areas. The MCAH/OFP Branch, in collaboration with the CIPPP, held an orientation teleconference and in-person meeting for the five newly funded local jurisdictions, in conjunction with the CIPPP conference. CIPPP has been working with the local jurisdictions to provide technical assistance on data analysis, program planning, and

evaluation.

The MCAH/OFP Branch's Childhood Injury Prevention Program, in collaboration with CIPPP, EPIC, and the UC Berkeley Center for Traffic Safety, applied for an Office of Traffic Safety grant to better understand the underlying factors for the recent increase in youth motor vehicle deaths and to provide usable tools for local programs to address this important public health issue. However, the Branch did not receive the grant.

### c. Plan for the Coming Year

The MCAH/OFP Branch will continue to coordinate activities with the Epidemiology and Prevention for Injury Control (EPIC) Branch and to collaborate to address joint areas of interest. The MCAH/OFP Branch participates in the SAFE KIDS California Advisory Committee and the Statewide Coalition on Traffic Safety and works with members of the Child Death Review Team Council. The CIPPP in collaboration with the MCAH/OFP Branch will continue to coordinate the list serve, injury prevention teleconferences, and weekly injury prevention literature reviews.

The 19th annual Childhood Injury Prevention Conference will be held in October 2005 in San Diego, CA. The theme for the conference is "Building Professional Skills and Increasing Capacity." The format of this year's conference will allow in-depth half day and full day trainings on a number of topics including: developing a thorough needs assessment; understanding, performing, and applying effective evaluations; developing successful grant proposals; enhancing program partners and resources; and applying smart growth concepts.

The MCAH/OFP Branch plans to continue and expand its list serve and teleconference to meet local jurisdictions' needs. The MCAH/OFP Branch will continue to work with SAFE KIDS California Advisory Committee, Statewide Coalition on Traffic Safety, and the Child Death Review Council. CIPPP, in collaboration with the MCAH/OFP Branch, will continue to work with MCAH programs to better incorporate injury prevention into their programs.

## Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 44.1 | 44.8 | 43.1 | 44 | 44.9 |
| Annual Indicator | 42.6 | 42.2 | 41.8 | 41.2 | 41.2 |
| Numerator | 218649 | 214716 | 209432 | 208855 | |
| Denominator | 513757 | 508723 | 500843 | 507143 | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

| | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|
| Annual Performance Objective | 41.7 | 42.2 | 42.7 | 43.2 | 43.7 |

**Notes - 2002**

Source: State of California, Department of Health Services, Genetic Disease Branch, California Newborn Screening Form, 2002. Tabulations were done by the Maternal and Child Health Branch. The year of birth is used instead of the process year.

**Notes - 2003**

Source: State of California, Department of Health Services, Genetic Disease Branch, California Newborn Screening Form, 2003. Tabulations were done by the MCAH/OFP Branch. The year of birth is used instead of the process year. Data represent the percent of women who exclusively breastfed their infants while in the hospital after giving birth.

**Notes - 2004**

A manual indicator is reported for 2004 based on 2003.

## a. Last Year's Accomplishments

Increasing the proportion of mothers who breastfeed their infants is an MCAH/OFP Branch priority for the period 2001-2005. The percent of mothers who were exclusively breastfeeding at the time of hospital discharge in California in 2000 was 42.6 percent. Since 2000, California's rate has declined slightly, to 41.2 percent in 2003, short of the annual objective of 44.0 percent for the year.

There remain disparities between racial and ethnic groups in the proportion of mothers who were breastfeeding exclusively at the time of hospital discharge. In 2003 White women had the highest percentage of mothers who breastfed (62.7 percent), followed by American Indian mothers (48.7 percent). Other groups were below the state rate: 39.2 percent of Asian mothers, 30.2 percent of African American mothers, 29.6 percent of Pacific Islander mothers, and 29.1 percent of Hispanic mothers were breastfeeding exclusively at hospital discharge.

Assembly Bill 1025 (2001) facilitates breastfeeding among women who return to work after childbirth by requiring all California employers to provide a reasonable amount of break time to accommodate an employee wishing to express breast milk, and to make a reasonable effort to provide a room for expressing milk in close proximity to the work area.

DHS holds statewide Public Health Grand Rounds sessions once a month, and in August of each year, the focus is on breastfeeding promotion. In 2004, the topic was "Exclusive Breastfeeding: Achieving the Gold Standard." Previous topics have included "Breastfeeding and the Law that Helps" and "The Impact of Infant Feeding on Obesity and Diabetes." These sessions on breastfeeding have been well-attended, with more than 150 participants. Local health department staff and other interested parties are able to participate via videoconferencing.

BIH promotes breastfeeding among African American women. Based on findings that African American women are less likely to initiate or sustain breastfeeding than most other race/ethnic groups, strategies for BIH program collaboration with local breastfeeding coalitions have been promoted and adopted in several counties.

CDAPP promotes breastfeeding as beneficial for both mother and child in reducing the risk for diabetes. CDAPP has added a chapter on breastfeeding to its Guidelines for Care for women with gestational diabetes, as well as for those who take insulin and breastfeed.

Working with AFLP, Cal-SAFE, and Cal-Learn, DHS is insuring that teen pregnancy programs

effectively promote breastfeeding among this age group of mothers that is less likely to breastfeed.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. The AFLP promotes breastfeeding among adolescent mothers, an age group that is less likely to breastfeed. | | X | | |
| 2. The CDAPP promotes breastfeeding as beneficial for both mother and child in reducing the risk for diabetes. | | X | | |
| 3. The BIH program promotes breastfeeding among African American women. | | X | | |
| 4. The MCAH/OFP and CMS Branches are participating on the DHS Nutrition and Physical Activity Action Team; breastfeeding promotion is one of the interventions for childhood obesity prevention. | | | | X |
| 5. MCAH/OFP Branch staff help promote local breastfeeding coalitions, including working with a team from UCD to organize an annual Statewide Breastfeeding Coalition Conference. | | | | X |
| 6. The MCAH/OFP Branch and RPPC are providing tool kits and technical assistance to nurses at labor and delivery hospitals to improve hospital lactation policies. | | X | | |
| 7. DHS annually holds a statewide Public Health Grand Rounds session on breastfeeding promotion. | | | | X |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The California Breastfeeding Promotion Advisory Committee consists of representatives of hospital administrators, medical groups (such as the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics), state agencies (including MCAH/OFP, WIC, BIH, CMS, and AFLP), advocacy groups, and academia. The Advisory Committee meets twice a year. The most recent meeting (June 2-3, 2005) included presentations and discussion about data on breastfeeding (including hospital-specific rates), model hospital breastfeeding policies, training and technical assistance for hospitals, increasing breastfeeding rates for African Americans, obesity prevention, and organizing among local breastfeeding coalitions.

The MCAH/OFP Branch helps promote local breastfeeding coalitions, including working with a planning team from UC Davis to organize meetings of the CA Breastfeeding Coalition. Annual or semiannual conferences have been held since 2003. The most recent conference (March 2005) included presentations and discussion about needs assessment priority areas, funding strategies, strategies for improving breastfeeding rates, model hospital policies, excellence indicators, collaborative projects, and organizational development. Planning for the next Coalition Conference in Fall 2005 is now underway.

The MCAH/OFP Branch collaborates with WIC on many breastfeeding promotion activities. Current efforts are focused through the Breastfeeding Promotion Advisory Committee. The MCAH/OFP and WIC Branches share data on breastfeeding among perinatal populations. WIC

has lent MCAH/OFP a half-time Internationally Board Certified Lactation Consultant from March to September 2005. WIC is also evaluating an offer to provide training and technical assistance for all MCAH/OFP programs on lactation, in order to address disparities in African Americans and Hispanic lactation rates. The Lactation Consultant is working on a toolkit to assist hospitals to improve their hospital practices. In addition, she will be involved in training and technical assistance to the hospitals. Details of this activity are still being developed.

CPQCC's quality improvement toolkit on "Nutritional Support of the Very Low Birth Weight Infant" is now available via a link on the MCAH/OFP website. Current research indicates that human milk (with appropriate fortification for very low birth weight infants) is the standard of care for preterm nutrition, as well as term infant nutrition.

BIH, CDAPP, AFLP, CalSAFE, and CalLEARN continue to promote exclusive breastfeeding among their constituencies and through informational materials and professional organizations and meetings. The breastfeeding page of the MCAH/OFP website, which contains information about advocacy groups, sources of data, and other resources, is continually updated. The website contains hospital-specific data on the percentage of mothers who breastfeed their infants at discharge.

## c. Plan for the Coming Year

The MCAH/OFP Branch will be working on the following breastfeeding promotion activities in the coming year:

1) Provide tool kit and technical assistance to nurses at labor and delivery hospitals via RPPC to improve hospital lactation policies. Include use of quality assurance indicators.

2) Complete model hospital breastfeeding policies and post on MCAH/OFP website. Distribute to hospitals with hospital specific data.

3) Complete statewide breastfeeding surveillance report, including maps. Special attention will be given to Latinas and African Americans.

4) Complete the chapter on infant feeding for the California Daily Food Guide, focusing on breastfeeding as being the normal feeding method for infants.

5) Invite Licensing and Certification to any hospital related breastfeeding presentations by MCAH/OFP.

6) Via WIC, train African American and Hispanic women in MCAH/OFP programs to become peer counselors.

7) Include breastfeeding material in Genetic Disease Branch Alpha Feto Protein (AFP) informational packets for all women in California having an AFP test.

8) Address race/ethnic disparities in breastfeeding rates in all MCAH/OFP programs.

9) Improve cultural competency in breastfeeding interventions.

10) Include more information about the role of the father in breastfeeding interventions.

The MCAH/OFP and CMS Branches are participating on the DHS Nutrition and Physical Activity Action (NUPA) Team. NUPA has requested $6 million for FY 2005-2006 to launch an Obesity Prevention Initiative. This funding is included in the Governor's draft budget for 2005-2006. The initiative includes $1.4 million for working with Medi-Cal managed care plans to

design system changes that will improve delivery of healthcare services to prevent obesity in children, including the implementation of interventions to promote exclusive breastfeeding.

The WIC Branch has tallied the results of the Infant Feeding Policies and Practices Survey distributed to all hospitals in California. The survey results identify labor and delivery policies and practices associated with higher exclusive breastfeeding rates. The results of the survey will be distributed to hospitals and appropriate MCAH/OFP programs, such as the RPPC, where they will be used to work with the hospitals on becoming more breastfeeding friendly.

The theme of the next Breastfeeding Awareness month/week and the next breastfeeding Grand Rounds in August 2005 is " Breastfeeding and Family Foods: Loving and Healthy."

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 10 | 15 | 40 | 60 | 70 |
| Annual Indicator | 13.7 | 21.6 | 52.2 | 56.2 | 56.2 |
| Numerator | 73170 | 114166 | 276646 | 304469 | |
| Denominator | 532611 | 528609 | 530203 | 541760 | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 70 | 75 | 75 | 75 | 75 |

**Notes - 2002**

Measure based on hospitals carrying out universal newborn hearing screening in California. This measure is the percent of newborns who have been screened for hearing before hospital discharge.
Source: Numerator and denominator data are from the State of California, Department of Health Services, Office of Vital Records, birth certificate data.
Numerator: Number of newborns who have been screened for hearing before discharge for FY 2002.
Denominator: Number of live births by occurrence in California in FY 2002.

**Notes - 2003**

Measure based on hospitals carrying out universal newborn hearing screening in California. This measure is the percent of newborns who have been screened for hearing before hospital discharge.
Source: Numerator and denominator data are from the State of California, Department of Health Services, Office of Vital Records, birth certificate data.

Numerator: Number of newborns who have been screened for hearing before discharge for FY 2003.
Denominator: Number of live births by occurrence in California in FY 2003.

**Notes - 2004**

A Manual indicator is provided based on FY 2003 results.

## a. Last Year's Accomplishments

NPM 12 relates to population-based services for pregnant women, mothers and infants and is the percent of newborns who have been screened for hearing loss before hospital discharge. Based on information reported by the individual Hearing Coordination Centers (HCCs), 276,646 infants, or 52.2 percent of all California newborns, received newborn hearing screening prior to hospital discharge in FY 2002-03. This was an increase of 142 percent from FY 2001-02 and well above the objective of 40 percent.

California legislation only provides authority to implement the Newborn Hearing Screening Program (NHSP) in the 179 hospitals approved by the CCS program. The infants screened in FY 2002-03 comprise 78 percent of the target population. DHS only receives aggregate data reports from HCCs on a quarterly basis; this has affected the program's ability to accurately report the number of infants who receive screening, those who need follow-up, those identified with hearing loss, and those who have entered early intervention services.

The number of infants who received hearing screening prior to hospital discharge is based on NHSP program data that was reported from the hospitals to the Hearing Coordination Centers (HCC). This does not include any estimate of screening that may be occurring in non-CCS approved hospitals that do not report to the NHSP. There were 304,469 infants, or 56.2 percent of all newborns in California, who received newborn hearing screening prior to hospital discharge in FY 2003-2004. This represents an 8 percent increase from FY 2002-03 and is close to the objective of 60 percent.

Preliminary program data for FY 2004-2005 show that 372,595 infants, or 68.8 percent of all California newborns, received newborn hearing screening prior to hospital discharge. This is an increase of 22 percent from 2003, and very close to the annual objective of 70 percent.

Accomplishments in the past year include:

1) Activities taking place as part of the MCH Bureau grant include 3-part training sessions for community audiologists in performing infant diagnostic evaluations. These consist of a six-week on-line component, a two day on-site workshop, and a practical component. Three sessions were completed in August 2003 and another session was completed in June 2004.

2) The CMS Branch continues its participation on the Deaf and Hard of Hearing Early Intervention Workgroup, which has evaluated existing parent-infant curricula and begun drafting guidelines of assessment of infants and their families.

3) Physician educational materials were developed and included in a provider packet of materials that was disseminated at the American Academy of Pediatrics Annual Meeting in San Francisco in October, 2004.

4) The Sonoma State University administered a Parent Satisfaction Survey as part of an evaluation of the NHSP. Data analysis has begun.

5) The CMS Branch provided technical assistance and consultation support to HCCs.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. CMS MCHB grant provides training for community audiologists on intervention and amplification for infants with hearing loss. | | X | | |
| 2. CMS MCHB grant provides training for audiologist on diagnostic infant audiologic evaluations. | | X | | |
| 3. CMS participates and collaborates with the Early Start program on the Deaf and Hard of Hearing Early Intervention Workgroup. | | | | X |
| 4. Reprocurement of the Hearing Coordination Centers is in progress. | | X | | |
| 5. Program evaluation site visits of HCCs are performed as needed. | | X | | |
| 6. Efforts have been renewed to obtain a statewide data management system. | | X | | |
| 7. Parent Satisfaction Survey results under review by Sonoma State and CMS. | | X | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Current activities include:

1) A two-part training for community audiologists on intervention and amplification for infants with hearing loss was presented in two sessions during January 2005. Thirty-eight audiologists completed those training sessions. A three-part training on performing infant diagnostic evaluations was offered during the Spring of 2005.

2) The CMS Branch continues its participation and collaboration with the Early Start program on the Deaf and Hard of Hearing Early Intervention Workgroup. Guidelines for parent-infant curricula and infant assessment are being finalized.

3) The NHSP exhibited at the national American Academy of Pediatrics Annual Meeting in San Francisco in October 2004. Physician education and materials were provided to California physicians and to those from other states.

4) The California NHSP provided a plenary presentation on minimizing loss-to-follow-up at the national Early Hearing Detection and Intervention Conference in Atlanta in March 2005.

5) Results of the Parent Satisfaction Survey administered by Sonoma State University revealed that the average age at which parents were told their infant had a hearing loss was 5.2 months; the average age at referral to the Early Intervention program was 7.4 months; more than 95 percent of parents thought that the early intervention services were helpful; although 90 percent of the children had a regular doctor or primary care provider, only 63 percent received coordination of services consistent with a medical home; only 60 percent of parents had another parent with a child with hearing loss to talk with; and less than 25 percent of parents had heard of the statewide parent organization for families with children who have hearing loss.

6) Program evaluation site visit of the Bay Area/Coastal Hearing Coordination Center was performed in October. Report was provided to the HCC and corrective action plan is being negotiated.

7) Reprocurement of the Hearing Coordination Centers is in progress. A Request for Proposals was developed and released, proposals were reviewed and contractor selection will be announced.

8) Technical assistance and consultation support to HCCs continues.

### c. Plan for the Coming Year

Plans for the coming year include:

1) Two training sessions for community audiologists will be offered. One will be on intervention and amplification of infants with hearing loss. The other might be a diagnostic evaluation training or one on early intervention.

2) The CMS Branch will continue participation in an advisory capacity on the Deaf and Hard of Hearing Early Intervention Workgroup as it moves into training local early intervention providers in the curricula and assessment tools outlined in the report.

3) Program evaluation site visits are expected to be performed on existing HCC contractors. If new contractors are selected, then training and technical assistance will be needed to maintain continuity of services for the infants in the affected regions.

4) Efforts to obtain a statewide data management system for the NHSP will be renewed.

## Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 18 | 16.2 | 16.7 | 15.5 | 15.5 |
| Annual Indicator | 15.7 | 15.3 | 14.3 | 13.1 | 13.1 |
| Numerator | 1606084 | 1594275 | 1513479 | 1317215 | |
| Denominator | 10229830 | 10420100 | 10583770 | 10055080 | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 12.9 | 12.8 | 12.7 | 12.6 | 12.5 |

**Notes - 2002**

Source: The percent of uninsured children (age 0-18) is from the University of California Los Angeles (UCLA) Center for Health Policy Research and based on Current Population Survey 2003.

Numerator: an estimate derived by multiplying the percent uninsured by the denominator.
Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 1970-2040. Sacramento, California. December 1998.
http://www.dof.ca.gov/html/Demograp/Race.htm. Tabulations were done by the Maternal and Child Health Branch.

**Notes - 2003**

Source: The percent of uninsured children (age 0-18) is from the Kaiser Commission on Medicaid and the Uninsured and Urban Institute analysis of the 2004 March Current Population Survey.
Numerator: Derived by multiplying the percent uninsured by the denominator.
Denominator: Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, May 2004.
http://www.dof.ca.gov/html/Demograp/DRU_datafiles/Race/RaceData_2000-2050/California.txt.

**Notes - 2004**

A manual indicator is reported for 2004 based on 2003.

## a. Last Year's Accomplishments

The percent of children in California aged 0-18 who were uninsured declined from 15.7 percent in 2000 to 13.1 percent in 2003. The annual objective of 15.5 percent for 2003 was achieved. While the trend is in the right direction, the number of uninsured children is still high - about 1.3 million in 2003. The Healthy People 2010 objective is zero percent uninsured.

California's data for NPM 13 are for children ages 0-18 and are based on the U.S. Current Population Survey. Estimates derived from the California Health Interview Survey (CHIS) cover a slightly different age cohort (ages 0-17), but the results are similar. According to CHIS, 1.3 million children (14.3 percent) lacked health insurance coverage or experienced gaps in coverage in 2001. [52]

CHIS data on health coverage are available by race/ethnicity and immigration status and show notable disparities. Of race/ethnic groups, Hispanic and American Indian children have the highest rates of uninsurance, at 24 percent and 17 percent, respectively. The rates were 9 percent for Asians, 8 percent for Whites, and 6 percent for African Americans. [53] The rate of uninsurance was also very high (25 percent) for children whose parents (one or both) were undocumented.[54]

Insurance coverage rates depend largely on three sources of coverage: job-based insurance, Medi-Cal and HF. There is considerable variation in patterns of coverage by race/ethnicity. The children with the highest rates of coverage through Medi-Cal are African American (40 percent) and Hispanic (34 percent), with lower rates of coverage for Asian/Pacific Islander (19 percent) and White (11 percent). The children with the highest rates of coverage through HF are Hispanic (8 percent) and Asian/Pacific Islander (6 percent), with lower rates of coverage for African American (2 percent) and White (2 percent). The children with the highest rates of job-based coverage are White (77 percent) and Asian/Pacific Islander (65 percent), with lower rates of coverage for African American (53 percent) and Hispanic (36 percent). [55]

In an effort to decrease the number of uninsured children, DHS and MRMIB (administrator of HF) have developed a comprehensive outreach and education campaign to increase enrollment in Medi-Cal and HF. Efforts to reduce administrative barriers to enrollment included a shortened joint application for both Medi-Cal and HF, the elimination of quarterly status reports under Medi-Cal, and an on-line enrollment system. Health-e-APP, a web-based HF application, became available in 2003 and has improved speed, accuracy, and consumer satisfaction with the application process.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. MCAH/OFP programs encourage and facilitate enrollment in Medi-Cal and HF via education and assistance efforts. | | | X | |
| 2. The CMS Branch works to maximize the effectiveness of the Gateway for enrolling eligible children in Medi-Cal or HF. | | | | X |
| 3. CHDP provides information and materials in multiple languages for the Gateway. | | | | X |
| 4. DHS and MRMIB continue to implement and support improvements in the process of eligibility determination and enrollment for Medi-Cal and HF. | | X | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

The number of uninsured children in California could be reduced by two-thirds if all children eligible for public insurance programs were enrolled. [56] MCAH/OFP programs, including AFLP, ASPPP, BIH, BWSP, and CPSP, encourage and facilitate enrollment in Medi-Cal and HF. Other efforts to enroll eligible children into Medi-Cal and HF, including public awareness media campaigns and other community education efforts, are ongoing.

Through the CHDP Gateway, any child under 19 years old with family income at or below 200 percent FPL (and not already in the MEDS system) is "presumed eligible" for Medi-Cal or HF and is given a temporary Medi-Cal Benefits Identification Card. With this card, a child has access to no-cost, full-scope fee-for-service Medi-Cal benefits for up to 60 days. From July 2003 through February 2005, 1,197, 539 children were pre-enrolled in the Gateway, and 961,162 (80 percent) requested a joint application for Medi-Cal and HF.

Local CHDP programs inform new providers about the Gateway and direct these providers to CHDP Gateway resources. The CMS Branch made modifications to the Gateway pre-enrollment process that allow the Gateway transaction to identify and "deem" certain infants under one year of age as eligible for ongoing, full scope, no cost Medi-Cal at the time of a CHDP assessment. These modifications were effective June 1, 2004.

Certified application assisters (CAAs) work with families in clinics, community centers, schools, and homes, helping them to navigate the complex eligibility structures of Medi-Cal and HF, under which one child in a family may be eligible for Medi-Cal and another for HF or another state program. Many CAAs are bilingual or multilingual. Formerly CAAs received $50 for each application that resulted in a successful enrollment. State funding for the CAAs was terminated as of July 2003, due to the state budget crisis, but some CAAs continue working on a county-funded or volunteer basis, and the State continues to provide CAA trainings.

## c. Plan for the Coming Year

MCAH/OFP programs, including AFLP, ASPPP, BIH, BWSP, and CPSP, will continue to encourage and facilitate enrollment in Medi-Cal and HF.

The CMS Branch will continue to analyze CHDP Gateway data reports to monitor program operations and the needs of CHDP local programs and CHDP providers.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 63.6 | 60.3 | 60.3 | 61.7 | 61.7 |
| Annual Indicator | 60.8 | 60.9 | 61.7 | 70.9 | 70.9 |
| Numerator | 2617000 | 2636340 | 2869240 | 3137700 | |
| Denominator | 4303440 | 4326340 | 4650840 | 4425540 | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 72 | 72.5 | 73 | 73.5 | 74 |

**Notes - 2002**

Sources: California Department of Health Services, Medical Care Statistics Section compiled data to duplicate HCFA-2082 report for eligibles and recipients. Numerator: A five percent sample of unduplicated counts of Medi-Cal recipients ages 20 and under during October 2001 through September 2002 was used to estimate the number of clients that received a service. This estimate may not include all Medi-Cal managed care data because, at the time of the run, the tape may not have included all managed care reports. Denominator: Medical Care Statistics Section special run to estimate the monthly average number of Medi-Cal enrollees aged 20 and under during October 2001 through September 2002. The number of children eligible but not enrolled in Medi-Cal was obtained from a report from the UCLA Center for Health Policy Research, Health Policy Fact Sheet: "Number of Uninsured Californians Declines to 6.2 million" (March, 2002) that used data from the 2001 Current Population Survey. This was the same estimate used last year because no new estimate was available this year. The denominator was the total of the estimated number of enrollees plus the estimated number of eligible but not enrolled in Medi-Cal.

**Notes - 2003**

Sources: California Department of Health Services, Medical Care Statistics Section compiled data to duplicate HCFA-2082 report for eligibles and recipients. Numerator: A five percent sample of unduplicated counts of Medi-Cal recipients ages 20 and under during October 2002 through September 2003 was used to estimate the number of clients that received a service. This estimate may not include all Medi-Cal managed care data because, at the time of the run,

the tape may not have included all managed care reports. Denominator: Medical Care Statistics Section special run to estimate the monthly average number of Medi-Cal enrollees aged 20 and under during October 2002 through September 2003. The number of children eligible but not enrolled in Medi-Cal was obtained from the California Health Interview Survey, 2003 (http://www.chis.ucla.edu/main/DQ2/geographic.asp)
The denominator was the total of the estimated number of enrollees plus the estimated number of eligible but not enrolled in Medi-Cal.
Note: A new data source was used for the estimated number of children eligible but not enrolled in Medi-Cal. Data from previous years should not be compared to 2003 data.

**Notes - 2004**

A manual indicator is reported for 2004 based on 2003.

## a. Last Year's Accomplishments

Performance Measure 14, the percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program, was 70.9 percent in 2003. (One of the three data sources used in calculating this measure has changed since last year. The number of children eligible but not enrolled in Medi-Cal is now obtained from the California Health Interview Survey, whereas it was formerly obtained from the Current Population Survey. Numbers reported here for years prior to 2003 have not been recalculated based on the new data source and are therefore not comparable to the numbers reported for 2003 and subsequent years. The annual objective for 2003 was based on the previous data source and is no longer applicable.)

The State has made a strong commitment to reducing the number of uninsured children in California and ensuring access to healthcare services. Activities have included:

1) Support of streamlined Medi-Cal eligibility processes that encourage continuous coverage;

2) Support for client case management by MCAH/OFP programs such as the AFLP and BIH to screen and assess children and adolescents for Medi-Cal eligibility and assist them in obtaining services needed;

3) Public education media campaigns and other community education efforts to encourage eligible families to obtain medical services, such as family planning, well child care, prenatal care, childhood immunizations, and dental care; and

4) Facilitation of the provision of Medi-Cal paid prenatal care services to adolescents by providing financial incentives to prenatal care providers.

Prior to and after launching the CHDP Gateway, many changes in policies and procedures at the state, local, and provider level have occurred. A Provider Manual and Local Program Guidance Manual have been distributed, the latter now in final form. Both manuals are now online. The CMS Branch has been preparing for statewide trainings on the Local Program Guidance Manual for CHDP local programs.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. MCAH/OFP programs provide client case management services including assisting families in obtaining health services for children. | | X | | |
| 2. MCAH/OFP programs provide community education efforts related to | | | X | |

| | | | | |
|---|---|---|---|---|
| families getting medical services. | | | | |
| 3. MCAH/OFP programs facilitate provision of adolescent prenatal care services by Medi-Cal providers. | | **X** | | |
| 4. The CMS Branch continues to work on improving relations with Medi-Cal providers in order to maintain existing providers and encourage new provider enrollment. | | | | **X** |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

MCAH/OFP programs, including AFLP, ASPPP, BIH, BWSP, and CPSP, continue to screen and assess children and adolescents for Medi-Cal eligibility and assist them in obtaining services needed.

The CHDP local program staff serve an important role in recruiting and enrolling new providers, and assisting and encouraging established providers about the CHDP program, including the Gateway. The recently finalized Local Program Guidance Manual ensures that there is uniformity among all local programs in daily functions and the Provider Manual is an up-to-date resource for enrollment, billing, the Gateway, and all program responsibilities. Statewide trainings are occurring in May 2005 for local CHDP programs regarding the Local Program Guidance Manual.

c. Plan for the Coming Year

MCAH/OFP programs, including AFLP, ASPPP, BIH, BWSP, and CPSP, will continue to screen and assess children and adolescents for Medi-Cal eligibility and assist them in obtaining services needed.

The CHDP local program staff will continue to recruit and enroll new providers and will utilize the Local Program Guidance Manual as a resource. Providers and their sites will be assessed using the new Facility and Medical Review Tools contained in the Local Program Guidance Manual. The CHDP Health Assessment Guidelines for CHDP providers are undergoing significant updating as many parts of the manual are outdated. Methods to provide family-centered care and culturally competent care are being interwoven throughout the manual.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Performance Objective | 1.2 | 1.2 | 1.1 | 1.1 | 1.1 |
| Annual Indicator | 1.1 | 1.1 | 1.2 | 1.2 | 1.2 |
| Numerator | 6075 | 6054 | 6127 | 6344 | |
| Denominator | 531276 | 527366 | 529237 | 540814 | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 1.2 | 1.2 | 1.2 | 1.2 | 1.2 |

**Notes - 2002**

Source: State of California, Department of Health Services, Center for Health Statistics, 2002 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH/OFP Branch. Observations with missing values were subtracted from the denominator when calculating the percentages.

**Notes - 2003**

Source: State of California, Department of Health Services, Center for Health Statistics, 2003 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH/OFP Branch. Observations with missing values were subtracted from the denominator when calculating the percentages.

**Notes - 2004**

A manual indicator is reported for 2004 based on 2003.

## a. Last Year's Accomplishments

NPM 15, the percent of very low birth weight (VLBW) infants among all live births, has been stable in California for the period 2000-2003, between 1.1 and 1.2 percent. In 2003, it was 1.2 percent, and the annual objective of 1.1 percent was not met. The Healthy People 2010 objective is 0.9 percent.

Stable rates since 1998 have coincided with strong programmatic efforts throughout California to focus on early prenatal care and adequate delivery for expectant at-risk mothers. There are currently more than 1,500 Medi-Cal obstetrical providers approved to provide CPSP services and approximately 165,000 women served annually.

African American infants remained twice as likely as infants of most other racial/ethnic groups to be born at VLBW in California. Among African American infants, the proportion of VLBW was 2.7 percent, compared to 1.8 percent of American Indian infants, and between 1.0 and 1.3 percent for infants of other racial/ ethnic groups.

BIH provided services to more than 14,000 pregnant and parenting African American women, infants, and children in 2003. BIH is active in the 17 counties which account for 94 percent of the State's African American births. BIH identifies pregnant and parenting African American women at risk for poor birth outcomes and provides them assistance in accessing and maintaining appropriate health care and other supportive services.

Pregnant adolescents, particularly young adolescents, are also at increased risk of delivering low birthweight infants. A primary goal of AFLP is to improve the birth outcomes for babies born to its adolescent clients. AFLP assists and encourages pregnant adolescents to access prenatal and other necessary health care early in their pregnancy, provides nutritional

counseling and works with teens to eliminate behaviors such as smoking and alcohol use which could contribute to poor birth outcomes.

The MCAH/OFP and CMS Branches collaborate with the California Perinatal Quality Care Collaborative (CPQCC), which advocates for performance improvements in perinatal and neonatal outcomes. CPQCC has more than 90 member hospitals, which account for most of the newborns requiring critical care in California. The fourteen Regional Perinatal Programs of California (RPPC) operate as a clearinghouse for current perinatal literature and provide hospitals with clinical competency standards as well as published hospital standards of care. The RPPCs support the implementation of clinical quality improvement strategies by collaborating with maternal and neonatal providers to address identified quality improvement projects.

The CMS Branch worked closely with CPQCC on reviewing and determining data elements that need to be collected for CCS-approved NICUs, and the CMS Branch now requires that all CCS-approved NICUs submit their data through CPQCC.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. The CPSP provides Medi-Cal eligible women with prenatal care, health education, and psychosocial and nutrition support services. | | X | | |
| 2. The AFLP assists and encourages pregnant adolescents to access early prenatal care and works with teens to eliminate behaviors such as smoking and alcohol use which could contribute to poor birth outcomes. | | X | | |
| 3. The BIH program identifies pregnant and parenting African American women who are at risk for poor birth outcomes and provides them assistance in accessing and maintaining appropriate health care and other supportive services. | | X | | |
| 4. BIH educates women on how to recognize the signs and symptoms of preterm labor and advises women on how to prevent preterm labor. | | X | | |
| 5. The MCAH/OFP and CMS Branches are collaborating with the March of Dimes on their Prematurity Prevention Campaign and their Alcohol and Pregnancy Campaign. | | | X | |
| 6. The Regional Perinatal Programs of California (RPPCs) match the needs of high risk perinatal patients with the appropriate type of care by developing a multi-tiered network of care providers and facilities within specific geographic areas. | | X | | |
| 7. The CA Perinatal Quality Care Collaborative (CPQCC) collects data from 90 member hospitals, recommends quality indicators and performance improvement objectives, and assists providers in translating the data into improved patient care. | | | | X |
| 8. The CA Preconception Care Initiative is developing a provider/patient resource packet which describes essential, cost-effective elements of preconception care for improving maternal health and reducing the risk of birth defects and preterm labor. | | X | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

CPSP, AFLP, and BIH continue to work to decrease the incidence of low birth weight infants by providing Medi-Cal eligible women with comprehensive services including prenatal care, education, and psychosocial support.

The RPPCs assure access to risk-appropriate perinatal care while providing quality improvement activities at delivery hospitals and working to connect agencies, providers, and individuals. The RPPCs work to match the needs of high-risk perinatal patients with the appropriate type of care by developing a multi-tiered network of care providers and facilities within specific geographic areas.

The MCAH/OFP and CMS Branches are collaborating with the March of Dimes on its 5-year Prematurity Campaign (2003-2007). The goal of this $75 million campaign is to invest in research, education and community programs in order to identify the causes of prematurity and develop strategies to improve birth outcomes. The five aims of the Prematurity Campaign are to: 1) raise public awareness; 2) educate pregnant women about the signs of preterm labor; 3) assist practitioners with risk reduction tools; 4) invest in research into the causes of preterm birth; and 5) increase women's and children's access to health insurance.

The March of Dimes Prematurity Prevention Initiative Project Director is also an RPPC Director. In addition, the State RPPC Program Manager and another RPPC Director were active members on the Preterm Labor Task Force that developed the Preterm Labor Assessment Toolkit.

The RPPC provides education in the implementation of the CPQCC toolkits to perinatal providers. Toolkits include: Antenatal Corticosteroid Toolkit; Improving Initial Lung Function: Surfactant and Other Means; Nosocomial Infection Prevention: Neonatal Perspectives, Practices and Priorities; Postnatal Steroid Administration; Nutritional Support of the Very Low Birth Weight Infant: Part I (released 2004); Early Onset Group B Streptococcus Prevention (released 2004); and Nutritional Support of the Very Low Birth Weight Infant: Part II (released 2005).

The RPPC also has responsibility for provider education on use of the March of Dimes Prematurity Toolkit. In addition, the RPPC Directors review the VLBW outcomes with each hospital and assist in the identification of areas for improvement.

The MCAH/OFP and CMS Branches are also collaborating on the March of Dimes Alcohol and Pregnancy Campaign, which aims to increase knowledge and awareness about the consequences of substance use during pregnancy. Alcohol and drug use during pregnancy continue to be a major cause of negative birth outcomes.

## c. Plan for the Coming Year

California will continue to strive to reduce the percent of VLBW newborns through increasing entry into prenatal care during the first trimester of pregnancy, assuring the delivery of newborns of high-risk women in appropriate facilities, and quality improvements in perinatal hospital services.

The MCAH/OFP Branch is collaborating and supporting the efforts of the American College of Obstetricians and Gynecologists, the California Academy of Family Physicians, the March of Dimes, the UCSF Center for Policy Studies, and Sutter Medical Center in improving the practice of preconception care.

The California Preconception Care Initiative is developing a provider/patient resource packet to assist health care providers. Covered topics include: smoking cessation; substance abuse, including alcohol; family planning; prevention, diagnosis and treatment of sexually transmitted

infections, including HIV; domestic abuse and violence; nutrition, folic acid use, and physical activity; mental health; oral health; optimal blood glucose control among women with preexisting diabetes; screening for hypertension; infections and immunizations, and exposure to medications which increase risk for congenital anomalies. In addition to the packet, clinical information will be disseminated through the Internet, regional conferences, DVD, and audio presentations.

The MCAH/OFP Branch has applied to CDC for a Prevention Specialist (PS) for a period of two years to serve as the lead for a Statewide Preconception Health Task Workgroup. The PS and Task Workgroup will develop a statewide plan for implementing preconception health strategies and interventions. It is expected that the MCAH/OFP Branch will be notified in the summer of 2005 whether the CDC has approved the PS.

AFLP providers will continue to work in partnership with their adolescent clients toward improving the birth outcomes for at-risk teens through prenatal education and counseling as well as appropriate referrals for medical care.

BIH programs will continue to identify at-risk pregnant African American women and provide education and support. State and county BIH programs will also continue to collaborate with the March of Dimes Prematurity Prevention Campaign to increase awareness about preventing prematurity in the African American community.

CPSP will continue its work to decrease the incidence of low birth weight infants by providing Medi-Cal eligible women with comprehensive services including prenatal care, health education, and psychosocial and nutrition support services.

CMS will continue to review quarterly and annual CPQCC data reports of CCS-approved NICU hospitals. The MCAH/OFP Branch, the CMS Branch, RPPC and CPQCC will continue to work on increasing CPQCC membership. MCAH/OFP and CMS will continue to participate on the Perinatal Quality Improvement Panel. All these efforts are intended to help improve the quality of neonatal and perinatal care statewide.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| **Annual Objective and Performance Data** | **2000** | **2001** | **2002** | **2003** | **2004** |
|---|---|---|---|---|---|
| Annual Performance Objective | 4.2 | 5.9 | 5.4 | 4.7 | 4.6 |
| Annual Indicator | 5.2 | 4.9 | 4.7 | 5.0 | 5 |
| Numerator | 129 | 124 | 120 | 131 | |
| Denominator | 2464390 | 2516412 | 2560575 | 2617630 | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |

| | | | | | |
|---|---|---|---|---|---|
| Annual Performance Objective | 4.8 | 4.7 | 4.7 | 4.6 | 4.6 |

**Notes - 2002**

Source: State of California, Department of Health Services, Center for Health Statistics, 2002 California Death Statistical Master File. Selected Injury-Related Sections of ICD-10" as modified by the National Center for Health Statistics, Centers for Disease Control And Injury Prevention and Epidemiology and the Prevention for Injury Control (EPIC) Branch, California Department of Health Services. Tabulations (by place of residence) were done by the MCAH/OFP Branch.
Denominator: Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, May 2004.
http://www.dof.ca.gov/html/Demograp/DRU_datafiles/Race/RaceData_2000-2050/California.txt

**Notes - 2003**

Source: State of California, Department of Health Services, Center for Health Statistics, 2003 California Death Statistical Master File. Selected Injury-Related Sections of ICD-10" as modified by the National Center for Health Statistics, Centers for Disease Control And Prevention and Epidemiology and the Prevention for Injury Control (EPIC) Branch, California Department of Health Services. Tabulations (by place of residence) were done by the MCAH/OFP Branch.
Denominator: Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, May 2004.
http://www.dof.ca.gov/html/Demograp/DRU_datafiles/Race/RaceData_2000-2050/California.txt.
Rates for the years 2000-2002 may have changed from those reported in last year's report because they have been recalculated based upon updated population projections from the California Department of Finance. The new projections are based on the 2000 Census while data from previous reports were based on population projections from the 1990 Census.

**Notes - 2004**

A manual indicator is reported for 2004 based on 2003.

## a. Last Year's Accomplishments

The rate of suicide deaths among California youth declined between 1990 and 1998, from 9.2 to 6.3 per 100,000 youth. Between 1999 and 2002, the rate fluctuated around 5.0. In 2003, the rate was 5.0, and the annual objective of 4.7 was not met.

Suicide is one of the leading causes of death among American youth, and California is looking at ways to improve adolescent mental health. The Adolescent Health Collaborative (AHC), a broad-based, statewide group with representatives of the public and private sectors, identified the need for a comprehensive plan for addressing the health and developmental needs of California's adolescents. In response to this need, the MCAH/OFP Branch contracted with staff of NAHIC to develop a strategic plan to address adolescent health in 2001. The document provided background information and recommendations for future directions for the local adolescent health programs in California.

The State Adolescent Health Coordinator has been working with the Medi-Cal Managed Care (MCMC) Division, UCSF, and the Adolescent Health Working Group on a quality improvement project to improve preventive services for adolescents.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |

| | | | | |
|---|---|---|---|---|
| 1. MCAH/OFP collaborates with MCMC on their Interagency Work Group for the Behavioral, Emotional, and Social Screening and Treatment for Primary Care Providers (BEST-PCP). | | | | X |
| 2. MCAH/OFP participates in the multi-agency California Coalition for Youth Development, which promotes positive youth development through the annual Youth Development Summit and other projects. | | X | | |
| 3. At the local level, the AFLP and ASPPP providers routinely assess all adolescent clients for suicide risk and other mental health needs on an ongoing basis. | | X | | |
| 4. AFLP and ASPPP case management strategies include both youth development and risk reduction activities and services. | | X | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

The MCAH/OFP Branch collaborates with the MCMC Division on their Interagency Work Group for the Behavioral, Emotional, and Social Screening and Treatment for Primary Care Providers (BEST-PCP) Project. BEST-PCP focuses first on a discrete set of policy and structural issues at the state and county levels that must be addressed to facilitate meaningful change at the practice level. The project then aims to develop and implement a model for changing provider practice, as the basis for broader collaborative quality improvement efforts. The target population for this project is age 0-3 years. By addressing the behavioral, emotional, and social health of very young children, this model also has the potential for improvements in social, emotional, and mental health of children as they get older.

The MCAH/OFP Branch also participates in the multi-agency California Coalition for Youth Development. The coalition serves to promote positive youth development throughout California through the annual Youth Development Summit and other projects. Participants include the Attorney General's Office, the Department of Education, 4-H Center for Youth Development, Friday Night Live, the Department of Alcohol and Drug Programs, and the Department of Mental Health.

The California Adolescent Health Collaborative has received a Wellness Foundation Grant to educate stakeholders regarding Proposition 63, the Mental Health Services Act (MHSA), which passed in the fall of 2004. This new funding, from an additional one percent tax on personal income over $1 million, brings in $750 million a year. The funds will be distributed to local counties who are developing their own county mental health plans for the funding. The Collaborative has been sending out a Mental Health Policy Newsletter updating stakeholders on important mental health issues and updates on the MHSA.

## c. Plan for the Coming Year

Collaborations with MCMC and DMH on the BEST-PCP project will continue in order to better understand, coordinate, and implement change to improve the screening and treatment of behavioral, emotional, and social needs of our young children. The MCAH/OFP Branch will continue to look for opportunities to incorporate positive youth development into its programs and coordinate with others in the State to work to increase the assets of our youth. The MCAH/OFP Branch will continue to work with AHC and others to promote best practices in

mental health and to investigate best practices in suicide prevention.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 66.4 | 66.5 | 66.6 | 68.7 | 69.6 |
| Annual Indicator | 65.9 | 65.6 | 68.7 | 67.3 | 67.3 |
| Numerator | 4029 | 3969 | 3911 | 3970 | |
| Denominator | 6111 | 6054 | 5697 | 5900 | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 68.5 | 69 | 69.5 | 70 | 70.5 |

**Notes - 2002**

The proportions are considered conservative. They are based on the proportion of facilities designated by California Children's Services (CCS) as Regional or Community NICUs. Not all facilities that provide care appropriate for very low birth weight infants seek CCS designation. The Perinatal Facility Interviews conducted in 1995-96 found that 81% of very low birth weight infants were born in CCS-designated Regional and Community NICU facilities or facilities with equivalent levels of care (based on 305 facilities). Source: State of California, Department of Health Services, Center for Health Statistics, 2002 California Birth Statistical Master File and California Children Services, Approved Hospitals for NICUs (1999-2002) and other communications with CCS for 2002 data. Tabulations, by place of occurrence, were done by the MCAH/OFP Branch.

**Notes - 2003**

The proportions are considered conservative. They are based on the proportion of facilities designated by California Children's Services (CCS) as Regional or Community NICUs. Not all facilities that provide care appropriate for very low birth weight infants seek CCS designation. The Perinatal Facility Interviews conducted in 1995-96 found that 81% of very low birth weight infants were born in CCS-designated Regional and Community NICU facilities or facilities with equivalent levels of care (based on 305 facilities). Source: State of California, Department of Health Services, Center for Health Statistics, 2003 California Birth Statistical Master File and California Children Services, Approved Hospitals for NICUs (1999-2003) and other communications with CCS for 2003 data. Tabulations, by place of occurrence, were done by the MCAH/OFP Branch.

**Notes - 2004**

A manual indicator is reported for 2004 based on 2003 data.

## a. Last Year's Accomplishments

NPM 17, the percent of VLBW infants delivered at facilities for high-risk deliveries and neonates, was relatively stable in California at between 64.6 and 65.9 percent for the period 1998-2001. In 2002, it was up to 68.7 percent, but in 2003, it declined slightly to 67.3 percent. The annual objective of 68.7 percent for 2003 was not met. California is still far short of the Healthy People 2010 objective of 90 percent.

There was little variation by race/ethnicity in the percent of VLBW infants delivered at facilities for high-risk deliveries/neonates. The range was from a low of 64.3 percent for Asians to a high of 69.2 percent for African Americans. (Some race/ethnic groups, including American Indians and Pacific Islanders, had too few high-risk deliveries to be included in the comparison.)

The California figures are based on data from hospitals designated by the CCS program as Regional or Community NICU facilities. However, not all facilities providing care for VLBW infants seek certification by CCS.

The fourteen Regional Perinatal Programs of California (RPPC) provide regional planning and coordination to ensure that the needs of high-risk patients are matched with the appropriate level of care. RPPCs develop communication networks among agencies, providers, and individuals, and they disseminate education materials and produce a statewide newsletter. RPPCs assist hospitals with data collection and quality improvement activities. They also provide resource directories, referral services, and hospital linkages to the two California Perinatal Transport Systems (CPeTS).

CPeTS assists health care professionals in the referral of high-risk pregnant women and newborn infants. Bed availability status for regional neonatal intensive care units, updated daily, is available on the CPeTS website (www.perinatal.org). CPeTS also facilitates meetings of the Regional Transport Quality Improvement Committee.

The MCAH/OFP Branch has two complementary projects which provide data for perinatal quality improvement efforts in California: the Improved Perinatal Outcome Data Reports (IPODR) and California Perinatal Profiles. Their websites are http://datamch.berkeley.edu/ and http://perinatalprofiles.berkeley.edu, respectively. The IPODR are intended to provide information on which to base health planning and allocation decisions, and evaluation of these decisions. The IPODR website includes an annual county profile report based on California Birth/Death Vital Statistics and Hospital Discharge Data aggregated to the ZIP code level. The California Perinatal Profiles website provides both public (state and regional) information, as well as confidential (hospital specific) information, with the goal of providing data for quality improvement to all the maternity hospitals in California.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. The fourteen Regional Perinatal Programs of CA (RPPC) provide regional planning and coordination and ensure that the needs of high-risk patients are matched with the appropriate level of care. | | | | X |
| 2. The CA Perinatal Transport Systems (CPeTS) assist in the referral of high-risk pregnant women and newborn infants by providing bed availability status for regional CCS approved NICUs, updated daily, on the CPeTS website. | | X | | |
| 3. RPPC and CPeTS assist hospitals with data collection and quality | | | | |

| | | | | |
|---|---|---|---|---|
| improvement activities. | | | | X |
| 4. The CPQCC reports on neonatal care for hospital/NICU members of CPQCC, providing CCS a useful and uniform reporting scheme for comparative assessment of hospitals on level of care for neonates. | | | | X |
| 5. The Improved Perinatal Outcome Data Reports (IPODR), which include county profiles and other reports, are intended to provide information on which to base health planning and allocation decisions, and evaluation of these decisions. | | | | X |
| 6. The California Perinatal Profiles website provides both public (state and regional) information, as well as confidential (hospital specific) information with the goal of providing data for continuous quality improvement to all maternity hospitals | | | | X |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

The RPPC and CPeTS continue their work in the areas of regional planning and coordination, matching high-risk patients with the appropriate level of care, and assisting hospitals with data collection and quality improvement activities.

The RPPCs review all birth outcomes data, including IPODR and Perinatal Profiles data, with each hospital in their region and assist in the identification of areas for improvement. RPPC also provide technical assistance in the implementation of the CPQCC toolkits to perinatal providers. In addition, the RPPCs have teamed up with the DHS Office of Vital Statistics to convene regional meetings with local Birth Clerk and County Registrars to improve the collection of data on the birth certificate.

In 2004-2005 the RPPC conducted a statewide survey to assess the status of the CCS-required Regional Cooperation Agreements which define the core elements of perinatal regionalization. The survey also collected information on the status and requirements of regional perinatal transport systems. The RPPC, in collaboration with CPeTS, is now working on a report, based on the survey results, entitled "Assessing California's Maternal-Fetal and Neonatal Systems of Care -- 2005." It will be accompanied by a toolkit entitled "Agreements for Provision of Perinatal and Neonatal Care."

CPQCC and the UCLA Maternal Quality Improvement Group have partnered with the MCAH/OFP Branch to develop the Maternal Quality Collaborative, which undertakes data-oriented quality improvement activities to improve perinatal and neonatal outcomes. The Maternal Quality Improvement Leadership Council will include members from CCS, MCAH/OFP, MCMC, and Medi-Cal Policy Section. The Collaborative will measure maternal quality of care in California, and has begun by determining hospital-level outcomes for maternal/neonatal infections and postpartum hemorrhage.

The CMS Branch is collaborating with CPQCC in retrieval and analysis of NICU data for CCS approved NICUs. This collaboration offers CCS a useful and uniform reporting scheme for comparative assessment of hospitals on level of care for neonates. As of May 2004 there were more than 80 hospitals/NICUs enrolled in CPQCC. Since January 2004 CCS requires all CCS-approved NICUs to submit data on an annual basis to CPQCC; because of this new requirement, the number of CPQCC member hospitals has increased to over 100 as of June 2005. (For more information about CPQCC, see National Performance Measure 15.)

c. Plan for the Coming Year

The RPPC and CPeTS will continue their work in the areas of regional planning and coordination, matching high-risk patients with the appropriate level of care, and assisting hospitals with data collection and quality improvement activities.

RPPC will finalize and disseminate the Survey Report, "Assessing California's Maternal-Fetal and Neonatal Systems of Care -- 2005," and the Toolkit, "Agreements for Provision of Perinatal and Neonatal Care." RPPC will partner with CCS to develop strategies to assist hospitals to develop and implement Regional Cooperation Agreements.

CPQCC has convened a Perinatal Transport Sub-committee to develop and implement a web-based perinatal transport data collection system. The Sub-committee includes an expert panel of providers with experience in perinatal transport to identify data elements that will provide useful information and guide perinatal transport quality improvement processes.

The Maternal Quality Collaborative will identify and validate appropriate indicators that will be used to guide quality improvement projects for maternal, perinatal and neonatal care in California.

The CMS Branch and CPQCC will continue to 1) respond to CPQCC membership questions, and 2) review data element selection in an effort to decrease any unnecessary data element collection for hospitals. The CMS Branch will continue to analyze CPQCC data reports for CCS-approved NICUs, addressing outliers and concerns about quality of care. The MCAH/OFP and CMS Branches will continue participation on the CPQCC Executive Committee and the Perinatal Quality Improvement Panel (PQIP). (The PQIP is an executive subcommittee of CPQCC which oversees data analysis and quality improvement efforts.)

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| **Annual Objective and Performance Data** | **2000** | **2001** | **2002** | **2003** | **2004** |
|---|---|---|---|---|---|
| Annual Performance Objective | 84.5 | 85 | 85.9 | 87.4 | 88.4 |
| Annual Indicator | 84.5 | 85.4 | 86.5 | 87.3 | 87.3 |
| Numerator | 441712 | 442937 | 448955 | 464157 | |
| Denominator | 522452 | 518894 | 519307 | 531508 | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 89.4 | 90.4 | 91.4 | 92.4 | 92.4 |

**Notes - 2002**

Source: State of California, Department of Health Services, Center for Health Statistics, 2002 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH/OFP Branch. Cases in which the time of the first prenatal visit was unknown were excluded.

**Notes - 2003**

Source: State of California, Department of Health Services, Center for Health Statistics, 2003 California Birth Statistical Master File. Tabulations (by place of residence) were done by MCAH/OFP Branch. Cases in which the time of the first prenatal visit was unknown were excluded.

**Notes - 2004**

A manual indicator is reported for 2004 based on 2003 data.

## a. Last Year's Accomplishments

Improving access to first trimester prenatal care has been a long-term MCAH/OFP priority. California has made steady progress on NPM 18, with the rate increasing about one percentage point a year between 1998 and 2003. NPM 18 was 87.3 percent in 2003, up from 86.5 percent in 2002. The 2003 annual objective of 87.4 percent was not quite met. The Healthy People 2010 objective is 90 percent.

Women in two race/ethnic groups exceeded the statewide annual objective for 2003, while other groups did not. White and Asian women were more likely to receive prenatal care in the first trimester (90.9 percent and 89.5 percent, respectively) than women who were Hispanic, African American, American Indian, or Pacific Islander (85.2, 84.1, 75.6, and 72.4 percent, respectively.)

Several strategies have been used in California to improve prenatal care utilization. One was the expansion of Medi-Cal eligibility criteria, improved access to Medi-Cal through presumptive and continuous eligibility, a waived assets test, and reduced application paperwork. These were accomplished in California in the late 1980s.

Several state programs support improvements in adequate prenatal care through direct and indirect delivery of services and support; these include the Comprehensive Perinatal Services Program (CPSP), the Adolescent Family Life Program (AFLP), the Women, Infants, and Children Supplemental Nutrition Program (WIC), the Black Infant Health (BIH) Program, and the American Indian Infant Health Initiative (AIIHI). The programs provide case management services and linkages to medical care for their target populations.

The MCAH/OFP Branch works to provide ethnically diverse staff for recruiting clients into care, and local MCH jurisdictions employ a variety of methods to target diverse populations. The MCH program in Orange County works with Latino Health Access, a local non-profit organization, to operate the Promotores Program. Promotores are highly trained community health workers who provide wellness education and act as role models for their peers. They are recruited and hired from the communities where they live. Promotores, in conjunction with public health professionals, work with pregnant Hispanic women and their families to promote early prenatal care and access to other appropriate healthcare services.

In spite of efforts to increase the number of women who receive prenatal care in the first trimester, the following obstacles remain: delays due to lack of awareness of Medi-Cal Presumptive Eligibility, delays due to the Medi-Cal enrollment process, and high rates of unintended pregnancy.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. The CPSP provides Medi-Cal eligible women with prenatal care, health education, and support services. | | X | | |
| 2. The BIH program identifies pregnant and parenting African American women who are at risk for poor birth outcomes and provides them assistance in accessing and maintaining health care and other support services. | | X | | |
| 3. The AFLP provides case management services to pregnant adolescents at risk of poor birth outcomes; services include nutritional and prenatal counseling and assisted referral for prenatal and other medical services. | | X | | |
| 4. The AIIHI serves prenatal and parenting American Indian women with direct health care services and case management services. | X | | | |
| 5. The MCAH/OFP Branch works to provide ethnically diverse staff for recruiting clients into care, and local MCH jurisdictions employ a variety of methods to target diverse populations. | | X | | |
| 6. The Family PACT Program provides no-cost family planning services to all low-income residents; insofar as these services help to reduce the rate of unintended pregnancy, they also contribute indirectly to increased utilization of prenatal care. | | X | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

CPSP, AFLP, WIC, BIH, and AIIHI continue to provide case management services and linkages to medical care for their target populations.

CPSP provides perinatal support services to 165,000 women a year, and reimbursement to the 1500 active CPSP providers is more than $88 million/year.

The MCAH/OFP Branch is working on consolidating data (beneficiaries, paid claims, birth outcomes, and hospital discharge data) to develop baseline data on the efficacy of CPSP services.

In California an estimated 44 percent of all births are unintended. [57] California's Family PACT Program provides no-cost family planning services to all California residents with incomes at or below 200 percent of the federal poverty level, and, insofar as these services help to reduce the rate of unintended pregnancy, they also contribute indirectly to increased utilization of prenatal care.

## c. Plan for the Coming Year

CPSP, AFLP, WIC, BIH, and AIIHI will continue to provide case management services and linkages to medical care for their target populations.

Plans for the coming year for CPSP include continued provider recruitment; provider and

practitioner training, including documentation training; material development; and development of evaluative reports on the efficacy of services. These activities are undertaken in an effort to ensure the availability and effectiveness of CPSP services, even in this era of budget constraints, and to achieve improvements in first trimester entry into prenatal care.

## D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *The percent of children whose family income is less than 200 percent of the Federal Poverty Level who received at least one preventive medical exam during the fiscal year.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 42.5 | 45.0 | 45 | 45 | 50 |
| Annual Indicator | 42.7 | 41.1 | 38.3 | 36.7 | 36.7 |
| Numerator | 1848738 | 1812655 | 1744626 | 1821315 | |
| Denominator | 4330878 | 4412824 | 4558136 | 4966062 | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 40 | 40 | 41 | 41 | 41 |

**Notes - 2002**

This measure is the percent of children whose family income is less than 200 percent of the Federal Poverty Level (FPL) who received at least one CHDP health assessment during the reporting year.
Source: CHDP program data and California census data.
Numerator is the number of children up to age 21 years who received at least one health assessment, as documented on the CHDP billing and reporting PM 160 Form for FY 2001-2002.
Denominator is the number of children up to age 21 years whose family income is less than 200 % of FPL for FY 2001-2002.
This measure as scored does not include health assessments given through the Healthy Families program, since this data is not yet available. Also Medi-Cal Managed Care plans are not consistently completing the PM 160 form, as this is an “information only” form for the plans.

**Notes - 2003**

This measure is the percent of children whose family income is less than 200 percent of the Federal Poverty Level (FPL) who received at least one CHDP health assessment during the reporting year.
Source: CHDP program data and California census data.
Numerator is the number of children up to age 21 years who received at least one health assessment, as documented on the CHDP billing and reporting PM 160 Form for FY 2002-

2003.
Denominator is the number of children up to age 21 years whose family income is less than 200 % of FPL for FY 2002-2003.
This measure as scored does not include health assessments given through the Healthy Families program, since this data is not yet available. Also Medi-Cal Managed Care plans are not consistently completing the PM 160 form, as this is an “information only” form for the plans.

**Notes - 2004**

A manual indicator is reported for 2004 based on 2003.

## a. Last Year's Accomplishments

SPM 01 addresses the utilization of preventive medical exams by children whose family income is below 200 percent of the FPL. CHDP data are used to calculate this measure. For FY 2001-02, of an estimated 4,558,136 target population, 1,744,626 children, or 38.3 percent, received CHDP health assessments. For FY 2002-03, of an estimated 4,966,062 target population, 1,821,315 children, or 36.7 percent received CHDP health assessments. This indicator is far below the objective of 45 percent and continues to decline.

There was an increase (4.4 percent) in the CHDP population receiving health assessments for FY 2002-03. However, the target population had a more sizeable increase of 8.9 percent for FY 2002-03. The CMS Branch continues to attribute much of the decline in this indicator to 1) children being transferred to other health care programs such as Healthy Families (HF), and 2) under-reporting of complete or partial CHDP preventive health assessments provided by MCMC plans.

HF provides services to children from eligible families up to 250 percent of the FPL. The data for preventive medical examinations received by children enrolled in HF are not reported to the CMS Branch. This lack of reporting will continue to negatively impact this performance measure, particularly as the number of HF clients continues to increase.

The CHDP "Information Only" PM 160 is used to report health assessment services rendered to Medi-Cal children enrolled in MCMC plans. Because they are not used as a billing form, the "Information-Only" PM 160's are not edited, and therefore the data from these forms may be less reliable than data reported on the other PM 160 forms. This potential under-reporting becomes more significant as increasing numbers of children are transitioning from Medi-Cal fee-for-service to MCMC plans.

In addition to under-reporting, the target population for this measure has increased 14.7 percent from FY 1999-00 to FY 2002-03.

Activities over the past year related to this measure have focused on implementation of the CHDP Gateway to enroll eligible children into Medi-Cal and HF. Local CHDP programs continue to work with providers in their counties to encourage provider participation in CHDP and to encourage provision of preventive services for children from families with incomes at or below 200 percent of the FPL. The CHDP Provider Manual was updated and placed on-line for easier access. A Local Program Guidance Manual was under development to provide consistency in conducting "business" across all the local programs.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. CHDP undertakes outreach efforts for children and families to access | | | | |

| | | | | |
|---|---|---|---|---|
| preventive health exams. | | X | | |
| 2. Local CHDP staff participate on the Head Start Advisory Board. | | X | | |
| 3. Local CHDP programs work with providers on implementing the Health Assessment Guidelines and recruiting providers. | | X | | |
| 4. The CMS Branch and local CHDP programs are facilitating the CHDP Gateway. | | X | | |
| 5. The CHDP Provider manual is online and is being updated. | | X | | |
| 6. The Local Program Guidance Manual (for consistency across CHDP programs) is online, and statewide trainings have been scheduled. | | X | | |
| 7. The CHDP Health Assessment Guidelines are being updated and revised; cultural competency and family-centered care are being integrated throughout. | | X | | |
| 8. CHDP programs work with schools to encourage comprehensive health assessments for new school entrants. | | X | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

Current activities related to this performance measure include:

1) Continuing the CHDP Gateway implementation;

2) Outreach efforts of the local CHDP programs and collaboration with the schools and Head Start to assist more low-income children to receive preventive exams;

3) Local health departments assisting children and their families to access preventive health examinations through health fairs and interagency agreements with WIC and Head Start;

4) Local CHDP staff participating on the Head Start Advisory Board;

5) Local CHDP programs continuing to work with providers in their counties to encourage provision of preventive services for children from families with incomes at or below 200 percent of the FPL;

6) In areas where access is limited, local CHDP staff working to recruit providers to participate in the CHDP program;

7) The Local Program Guidance Manual is undergoing finalization and a statewide training is being planned to instruct the local programs on the use of the Manual;

8) The CHDP Provider Manual is being updated; and

9) The CHDP Health Assessment Guidelines for CHDP providers are in the process of undergoing updating. The culturally competent evaluation and family-centered care are being emphasized in the updated Guidelines.

## c. Plan for the Coming Year

Plans for the coming year include:

1) Continuing the CHDP Gateway process.

2) Continuing CHDP collaboration with schools, Head Start and providers in order to assist more low-income children to receive preventive exams.

3) Continuing to provide health fairs in communities and to participate on the Head Start Advisory Board.

4) Local CHDP staff continuing to work toward recruiting providers to participate in the CHDP program.

5) Implementation of the CHDP Local Program Guidance Manual (including the new Facility and Medical Record Review Tools).

6) Continued work on the updating of the CHDP Health Assessment Guidelines to update them to reflect current standards of practice.

State Performance Measure 2: *The percent of low-income children who are above the 95th percentile of weight-for-length (less than 2 years) or BMI-for-age (2-12 years), or overweight.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| **Annual Objective and Performance Data** | **2000** | **2001** | **2002** | **2003** | **2004** |
|---|---|---|---|---|---|
| Annual Performance Objective | 14.0 | 14.0 | 14 | 14 | 14 |
| Annual Indicator | 14.9 | 17.2 | 16.1 | 17.8 | 17.8 |
| Numerator | 258147.1 | 208376 | 207872 | 214040 | |
| Denominator | 1732531 | 1214543 | 1294163 | 1205373 | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 14 | 14 | 13 | 13 | 13 |

**Notes - 2002**

This measure is the percent of low-income children under 12 years of age who are enrolled in the CHDP program and who are above the 95th percentile of weight-for-length (<2 years) or BMI-for-age (³2 years), or overweight. Source is the Pediatric Nutrition Surveillance System (PEDNSS), Centers for Disease Control and Prevention.
Numerator is the unduplicated number of children under 12 years of age enrolled in the CHDP program with weight-for-length or BMI derived from
the PM 160 form for FY 2001 that was above the 95th percentile for age.
Denominator is the unduplicated number of children under 12 years of age enrolled in the CHDP program with a weight and length/height measurement indicated on the PM 160 form for FY 2001-2002.

Note: For FY 2001, the new CDC growth charts were used, and the CDC unduplicated the data. Results are more accurate but cannot be compared with prior years.

**Notes - 2003**

This measure is the percent of low-income children under 12 years of age who are enrolled in the CHDP program and who are above the 95th percentile of weight-for-length (<2 years) or BMI-for-age (³2 years), or overweight. Source is the Pediatric Nutrition Surveillance System (PEDNSS), Centers for Disease Control and Prevention.
Numerator is the unduplicated number of children under 12 years of age enrolled in the CHDP program with weight-for-length or BMI derived from
the PM 160 form for FY 2002-03 that was above the 95th percentile for age. Denominator is the unduplicated number of children under 12 years of age enrolled in the CHDP program with a weight and length/height measurement indicated on the PM 160 form for FY 2002-2003.
Note: For FY 2000-01, the new CDC growth charts were used, and the CDC unduplicated the data. Results are more accurate but cannot be compared with prior years.

**Notes - 2004**

A manual indicator is reported for 2004 based on 2003.

## a. Last Year's Accomplishments

SPM 02 is the percent of low-income children 0 -12 years who are above the 95th percentile of weight-for-length (<2 years) or BMI-for-age (2-12 years), or overweight. Starting with the year 2000, the data used for this report from the PedNSS have been updated to utilize the 2000 CDC growth chart percentiles. CDC has also unduplicated the data for FY 2001-02 and this has improved accuracy and resulted in smaller numbers for both the numerator and the denominator. The percentage of overweight children for FY 2003-04 was 17.8 percent, a 10.6 percent increase from 16.1 percent for FY 2002-03 and a 19.5 percent increase from FY 2000-01. This indicator is well above the objective of 14 percent and reflects the difficulty nation-wide in making a positive impact on the obesity epidemic.

In the age group of 0 -12 years, American Indian/Alaskan Native have the highest prevalence for overweight (19.8 percent), followed by Hispanic (18.0 percent), and African American (14.9 percent); these results and those of other ethnic groups are essentially unchanged from FY 2002-03, resulting in flattening of the upward trend. The trends for overweight within every ethnic group have shown marked increases over the past ten years. In the 5 to <20 years age group, every ethnic group identified has shown another increase for FY 2003-04. In response to these trends, childhood obesity prevention has become a major statewide initiative.

The three CDC priority areas (increased physical activity, reduced television viewing, and breast feeding promotion) and the two promising areas (energy balance and five fruits and vegetables per day) for programs for reducing obesity have been assimilated into existing MCAH/OFP and CMS programs. The MCAH/OFP, CMS, and WIC Branches, and the UC Berkeley Center for Weight and Health collaboratively planned and developed the third biannual California Childhood Obesity Prevention Conference for January 2005. The MCAH/OFP and CMS Branches have been involved with program planning, implementation and evaluation in the CDC funded California Obesity Prevention Initiative (COPI). The MCAH/OFP and CMS Branches have actively participated in the DHS Physical Activity and Nutrition Coordinating Committee (PANCC).

A major initiative of DHS was the formation of a department-wide Nutrition and Physical Activity (NUPA) Team to address the role of DHS in confronting the obesity epidemic through the development of short, intermediate, and long term strategies for action to increase healthy eating and physical activity for all of California across all ages. These strategies were coordinated primarily within DHS. The MCAH/OFP and CMS Branches had representative participants on the NUPA Team.

In 2004, the Nutrition Network funded five CHDP Nutrition Special Projects in Merced, Sonoma, Yolo, San Bernardino, and San Francisco Counties. All the projects have a focus on nutrition and physical activity.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Data collection from CHDP nutrition assessments for the Pediatric Nutrition Surveillance System (PedNSS) continues. | | X | X | |
| 2. State and local CHDP nutritionists develop and implement nutrition education and provide consultation and training to CHDP providers. | | X | | |
| 3. The MCAH/OFP and CMS Branches plan the biannual CA Childhood Obesity conference. | | | | X |
| 4. The CMS and MCAH/OFP Branches participate in coalitions and committees on nutrition and physical activity. | | | | X |
| 5. The CMS and MCAH/OFP Branches participate on the DHS Nutrition and Physical Activity Action Team which is addressing the obesity epidemic in CA. | | | | X |
| 6. The MCAH In Schools Program endorses nutrional assessment tools including the CDC's School Health Index. | | X | | |
| 7. MCAH/OFP and CMS programs promote healthy eating and physical activity. | | | | X |
| 8. The MCAH/OFP and CMS Branches assist with program planning, implementation and evaluation for the CDC-funded CA Obesity Prevention Initiative (COPI). | | | | X |
| 9. The MCAH/OFP and CMS Branches actively participate on the Physical Activity and Nutrition Coordinating Committee (PANCC). | | | | X |
| 10. Two CHDP local programs are funded by the CA Nutrition Network for 2005 for CHDP Nutrition Special Projects. | | | X | |

b. Current Activities

An ongoing activity for the CMS Branch is the collection of data from CHDP nutrition assessments by CHDP providers for infants, children, and adolescents. The data is forwarded to CDC for entry into PedNSS. CDC prepares multiple informative tables from this data. In another ongoing activity, state and local CHDP nutritionists develop and implement nutrition education, provide consultation and training to CHDP providers, and coordinate follow-up and referrals to related programs.

The MCAH/OFP and CMS Branches, the California Department Of Education, and UC Berkeley Center for Weight and Health developed and sponsored a third biannual California Childhood Obesity Conference from January 9 -12, 2005 in San Diego. The conference theme was, "Launching a Movement: Linking Our Efforts to Make a Difference." A website was established for information: http://www.cce.csus.edu/cts/co/index.htm. The 2005 conference plenaries and sessions addressed issues related to childhood overweight and obesity from a variety of perspectives, including the healthcare industry, community-based organizations, research and evaluation groups, educators, pre-schools, schools, after-school programs, parents and families, and policy and marketing advocates. Sessions highlighted healthy eating and physical activity strategies and tools appropriate for low-income populations that attendees could adopt in their communities.

The MCAH in Schools Program (formerly called School Health Connections) promotes healthy food choices and physical activity in schools through the endorsement of nutritional assessment tools, including the CDC's School Health Index. The AFLP, ASPPP, and the oral health programs are promoting healthy food choices and physical activity. The BIH program and the CPSP promote breastfeeding in an effort to reduce the risk of developing obesity.

The BIH Program promotes proper nutrition by encouraging healthy eating through discussions on how to cut the fat and lower the calories in the menu. It features classes on "making ends meet on a limited budget." This incorporates meal planning, grocery shopping, stretching supplies, etc., and working collaboratively with nutritionists on the promotion of healthy eating and living.

MCAH/OFP and CMS continue to participate on the DHS NUPA Team under the direction of the DHS Public Health Medical Officer. This team has been prioritizing strategies that increase healthy eating and physical activity for all of California. The NUPA Team has proposed a $6 million comprehensive Obesity Prevention Initiative consisting of community action projects, a health quality collaborative, tracking and evaluation of data, worksite interventions, and public awareness and education activities. The proposal is included in the draft of the FY 2005-2006 Governor's budget.

## c. Plan for the Coming Year

The MCAH/OFP and CMS Branches will continue to actively participate in coalitions and committees promoting nutrition and activity. The NUPA Team will be instrumental in helping to develop a Governor's Summit on the obesity epidemic to be held in September 2005. Planning has begun and will continue for the fourth biannual California Childhood Obesity Conference in Anaheim, California January 24-26, 2007. Yolo and Sonoma Counties will continue work for the CHDP Nutrition Special Projects.

The NUPA Team will continue to serve as an advisory group for DHS and other agencies regarding nutrition and physical activity issues and particularly issues surrounding the obesity epidemic, and will be responsive to funding opportunities.

The California Nutrition Network for Healthy, Active Families is a public/private partnership led by DHS. The purpose of the Network is to promote healthy eating and a physically active lifestyle among low income Californians by using social marketing techniques to reach large numbers of people. In addition to DHS, Network partners include DSS, CDE, the Department of Food and Agriculture, and the University of California Cooperative Extension.

The MCAH/OFP Branch has been funded by the Nutrition Network to undertake projects in two counties, Contra Costa and Fresno. In Contra Costa County nutrition education and information will be provided to AFLP, BIH, CPSP, and Cal-Learn participants as well as in eight elementary schools and one middle school. In Fresno County, the project involves the development of a toolkit and training for providers who serve low-income families with young children. The toolkit will include written materials and video in English, Spanish and Hmong.

CHDP local programs in Yolo and Sonoma Counties have been funded by the Nutrition Network for Special Projects in 2004-2005. Yolo County is developing a video series (for agencies, providers and local public cable channel) of healthy cooking demonstrations in English and Spanish. Sonoma County, in addition to actively participating in the Family Nutrition Activity Task Force (FNATF), is targeting 100 food stamp eligible children (and their parents) identified as "at risk" for developing diabetes and hypertension to receive culturally appropriate education aimed at promoting an active lifestyle and healthy eating habits.

A substantial number of counties are also addressing obesity with their Title V plans. For example, Humboldt County has a North Coast Child Nutrition Task Force that provides networking opportunities for health professionals advocating for reduced obesity and improved activity for young children in the county. Marin County also has a task force in addition to providing nutrition education at a local Latino Community Center, sponsoring a Nutrition Help Line, and sponsoring an interactive exhibit, Nutrition Town, which can be customized to different target populations.

State Performance Measure 3: *The rate of deaths per 100,000 children aged 1 through 4 years caused by drowning in swimming pools.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 1.9 | 2.0 | 2.1 | 1.6 | 1.6 |
| Annual Indicator | 2.4 | 2.4 | 1.9 | 1.2 | 1.2 |
| Numerator | 48 | 48 | 38 | 25 | |
| Denominator | 1990873 | 1960105 | 1976342 | 2008528 | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 1.1 | 1.1 | 1.1 | 1.1 | 1.1 |

**Notes - 2002**

Source: Numerators: State of California, Department of Health Services, Center for Health Statistics, 2002 California Death Statistical Master File.
Denominator: Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, May 2004.
http://www.dof.ca.gov/html/Demograp/DRU_datafiles/Race/RaceData_2000-2050/California.txt
Tabulations were done by the MCAH/OFP Branch.

**Notes - 2003**

Source: Numerators: State of California, Department of Health Services, Center for Health Statistics, 2003 California Death Statistical Master File.
Denominator: Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, May 2004.
http://www.dof.ca.gov/html/Demograp/DRU_datafiles/Race/RaceData_2000-2050/California.txt
Tabulations were done by the MCAH/OFP Branch.
Rates for the years 2000-2002 may have changed from those reported in last year's report because they have been recalculated based upon updated population projections from the California Department of Finance. The new projections are based on the 2000 Census while data from previous reports were based on population projections from the 1990 Census.

**Notes - 2004**

A manual indicator is reported for 2004 based on 2003.

## a. Last Year's Accomplishments

SPM 03, the rate of deaths to children caused by drowning in swimming pools, was fairly stable for 1999-2001, between 2.0 and 2.4 per 100,000. In 2002 it was down to 1.9 (a total of 38 deaths), and in 2003 it was down again to 1.2 (a total of 25 deaths). The annual objective of 1.6 for 2003 was achieved. (Numbers for the years 2000-2002 have changed slightly from those in last year's report because they have been recalculated based on updated population projections from the California Department of Finance. The new projections are based on the 2000 Census; numbers in previous reports were based on population projected from the 1990 Census.)

The Swimming Pool Safety Act, enacted in 1996, sets forth comprehensive statewide swimming pool safety guidelines. It requires that new residential pools be designed with safety features, such as a fence or safety cover, to help prevent young children from getting to a pool or spa when momentarily out of sight of their caregivers.

The Center for Injury Prevention Policy and Practice (CIPPP), at San Diego State University, serves as a resource center on child and adolescent injury prevention and provides technical assistance in the development, implementation and evaluation of injury prevention programs. CIPPP works with the MCAH/OFP Branch to organize the annual childhood injury prevention conference. CIPPP also produces Safety Literature updates with weekly references of current injury prevention articles.

The MCAH/OFP Branch funds local childhood injury prevention programs in five counties in three-year cycles. In 2002, CIPPP, in collaboration with the MCAH/OFP Branch, started a bi-monthly injury prevention teleconference with injury prevention professionals in the five counties funded at that time. The group expanded to include other interested MCH programs and other injury prevention stakeholders in 2003. The regular teleconferencing enables statewide networking, joint planning, and skill development. In addition, an injury prevention list serve was also started and is now available to all local MCAH jurisdictions. The list serve is used to give updates, alert programs of funding sources, and share information.

Working with CIPPP and local coalitions, MCAH/OFP has increased public awareness of the hazards of unprotected swimming pools and has undertaken education efforts regarding legislation that requires fencing around swimming pools.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. The MCAH/OFP Branch funds five local childhood injury prevention programs in three-year cycles. | | X | | |
| 2. Local injury prevention efforts address pool safety interventions; examples include life jacket loaner programs, injury prevention during home visits, and compilation and analysis of local injury prevention data. | | X | | |
| 3. The Center for Injury Prevention Policy and Practice (CIPPP) at SDSU provides data and technical assistance to local injury prevention programs and assists in creating linkages between agencies, researchers, and advocates. | | | | X |
| 4. To raise funds to support child injury and abuse prevention programs, including child drowning prevention efforts, the State sells special car | | X | | |

| | | | | |
|---|---|---|---|---|
| license plates, called Kid's Plates. | | | | |
| 5. The MCAH/OFP Branch holds regular meetings with the Epidemiology and Prevention for Injury Control (EPIC) Branch to coordinate activities and collaborate to address joint areas of interest. | | | | **X** |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

The MCAH/OFP Branch funds local childhood injury prevention programs in five counties in three-year cycles. Beginning July 1, 2004, the jurisdictions of Plumas, Siskiyou, Sacramento, Stanislaus, and Ventura began receiving funding for three years.

The 18th Annual Childhood Injury Prevention Conference was held September 27-29, 2004, in San Francisco to provide the latest information on practices and research in injury prevention and to provide in-depth training in specific areas. The MCAH/OFP Branch, in collaboration with the CIPPP, held an orientation teleconference and in-person meeting for the five newly funded programs, in conjunction with the September conference. CIPPP is working with the local jurisdictions to provide technical assistance on data analysis, program planning, and evaluation.

The MCAH/OFP Branch collaborates with the Epidemiology and Prevention for Injury Control (EPIC) Branch to coordinate activities and collaborate to address joint areas of interest.

Local injury prevention efforts continue to address pool safety interventions. Modoc County has an injury prevention program and dedicated injury prevention staff who address a wide variety of injury prevention concerns with a focus on children 1- 10 years of age. Lassen County promotes injury prevention through their home visitation activities and is in the process of compiling and analyzing injury prevention data. Humboldt County has obtained funding and hired a coordinator to plan and implement a local Childhood Injury and Prevention Program.

To raise funds to support child injury and abuse prevention programs, the State sells personalized auto license plates, called "Kid's Plates". Kids Plates feature a heart, hand, star, or plus sign. The proceeds fund child injury and abuse prevention programs. The Kid's Plates Program provides a wide range of technical assistance to help foster effective regional and local injury prevention efforts and funds grants for training and equipment. Between 1998 and 2003, over 200 grants were awarded to community-based organizations, local health departments, and other organizations. CIPPP is the Kid's Plate program administrator for the EPIC Branch.

## c. Plan for the Coming Year

The 19th annual Childhood Injury Prevention Conference will be held October 2-5, 2005, in San Diego, Ca. The theme for this conference is, "Building Professional Skills and Increasing Capacity." The format of this year's conference will allow in-depth half day and full day trainings on a number of topics including: developing a thorough needs assessment; understanding, performing, and applying effective evaluations; developing successful grant proposals; enhancing program partners and resources; and applying smart growth concepts.

DHS will continue to support programs and projects which work to prevent childhood injury. DHS will continue to support CIPPP in its efforts to provide data and technical assistance in the

development, implementation, and evaluation of injury prevention programs and assist in creating linkages between agencies, researchers, and advocates.

State Performance Measure 4: *The rate of deaths per 100,000 adolescents aged 15 through 19 years caused by homicide.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 11.9 | 13.8 | 13.5 | 13.7 | 13.7 |
| Annual Indicator | 13.2 | 12.9 | 13.3 | 14.2 | 14.2 |
| Numerator | 325 | 325 | 341 | 371 | |
| Denominator | 2464390 | 2516412 | 2560575 | 2617630 | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 13.7 | 13.7 | 13.7 | 13.7 | 13.7 |

**Notes - 2002**

Source: Numerators: State of California, Department of Health Services, Center for Health Statistics, 2002 California Death Statistical Master File.
Denominator: Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, May 2004.
http://www.dof.ca.gov/html/Demograp/DRU_datafiles/Race/RaceData_2000-2050/California.txt
Tabulations were done by the MCAH/OFP Branch.

**Notes - 2003**

Source: Numerators: State of California, Department of Health Services, Center for Health Statistics, 2003 California Death Statistical Master File. "Selected Injury-Related Sections of ICD-10" as modified by the National Center for Health Statistics, Centers for Disease Control and Prevention and Epidemiology and the Prevention for Injury Control (EPIC) Branch, California Department of Health Services.
Denominator: Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, May 2004.
http://www.dof.ca.gov/html/Demograp/DRU_datafiles/Race/RaceData_2000-2050/California.txt
Tabulations were done by the MCAH/OFP Branch.
Rates for the years 2000-2002 may have changed from those reported in last year's report because they have been recalculated based upon updated population projections from the California Department of Finance. The new projections are based on the 2000 Census while data from previous reports were based on population projections from the 1990 Census.

**Notes - 2004**

A manual indicator is reported for 2004 based on 2003.

## a. Last Year's Accomplishments

The adolescent homicide rate fell steadily between 1994 and 1999, from 34.4 to 13.6 deaths per 100,000. Between 2000 and 2002, it hovered between 12.9 and 13.3. The 2003 rate was 14.2 (a total of 371 deaths); the annual objective of 13.7 was not achieved. (Numbers for the years 2000-2002 have changed slightly from those in last year's report because they have been recalculated based on updated population projections from the California Department of Finance. The new projections are based on the 2000 Census; numbers in previous reports were based on population projected from the 1990 Census.)

There are very large differences in the adolescent homicide rate by race/ethnicity. African-Americans had an adolescent homicide rate of 51.9, more than double the Hispanic rate and more than 8 times higher than the rate for any other racial/ethnic group.

California law restricts the types of weapons that individuals can purchase, requires background checks of gun purchasers (including waiting periods), and requires citizens wishing to carry concealed weapons to obtain permits to do so. California school districts have also begun to implement programs to enhance school safety through a variety of strategies ranging from conflict resolution training to increased collaboration with local police departments.

DHS conducts ongoing injury surveillance to look at broad statewide patterns and gathers data to better understand the risk factors and circumstances that can lead to specific types of injury. The Epidemiology and Prevention for Injury Control (EPIC) Branch has an online injury prevention database that generates individualized county level tables (by age, race, location, etc.). Local MCAH jurisdictions have utilized this resource to assist with program planning. Two surveillance projects of special interest by EPIC include a statewide child abuse and neglect fatality monitoring system and the Firearm Injury Surveillance Program. These projects provide data on incidence for program planning purposes and to inform policy makers of possible changes in regulations or direction of injury control programs.

The School/Law Enforcement Partnership (S/LE Partnership), between the CDE and the Attorney General's Crime and Violence Prevention Center, encourages schools and law enforcement agencies to develop interagency partnerships and activities that improve school attendance, encourage good citizenship, and promote safe schools. The S/LE Partnership administers the new School Community Violence Prevention Program that was established in 2004. This $16.3 million program consolidated several school safety grants funded in previous years.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. The Safe from the Start Project, in the California Office of the Attorney General, targets children age 18 and younger, with an emphasis on children age 5 and younger, who have been exposed to family, school and/or community violence. | | X | | |
| 2. The School Law Enforcement Partnership encourages schools and law enforcement agencies to develop interagency partnerships and activities that improve school attendance, encourage good citizenship, and promote safe schools. | | X | | |
| 3. The Carl Washington Act Program provides local education agencies with funding ($82 million/year statewide) to establish programs and strategies that promote school safety and emphasize violence prevention. | | X | | |

| | | | | |
|---|---|---|---|---|
| 4. In an effort to complement problem-focused responses on firearms and substance abuse with assets-based development of opportunities for youth, the MCAH/OFP Branch participates on the California Coalition for Youth Development. | | **X** | | |
| 5. The EPIC Branch's child abuse and neglect fatality monitoring system and the Firearm Injury Surveillance Program provide incidence data for program planning and evaluation. | | **X** | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

### b. Current Activities

The activities of the EPIC Branch and and the School/Law Enforcement Partnership, described above, are ongoing.

The "Safe from the Start" Project, in the California Attorney General's Office, targets children age 18 and younger, with an emphasis on children age 5 and younger, who have been exposed to family, school and/or community violence. They have created various materials, including a video, to address the issue of gangs, homicide and youth violence in California.

The Carl Washington School Safety and Violence Prevention Act Program provides local education agencies with funding to establish programs and strategies that promote school safety and emphasize violence prevention. These funds are allocated based on enrollment counts for grades 8-12 ($35/student/year) with a minimum allocation of $5,000 per school site, or $10,000 per school district, whichever is greater. The $82 million program is administered by CDE.

Assets-based development of opportunities for youth complement the problem- focused responses to such risks as adolescent access to firearms and substance abuse. The MCAH/OFP Branch has been a part of the California Coalition for Youth Development, a network of organizations throughout the state working to promote youth development in our programs.

### c. Plan for the Coming Year

The MCAH/OFP Branch plans to work with the EPIC Branch to assist in their grant application to develop a strategic plan for childhood and youth violence prevention.

The new Request for Applications from the School/Law Enforcement Partnership to local education agencies and their local law enforcement partners will be available from CDE in Fall 2005.

The MCAH/OFP Branch will continue to look for opportunities to promote youth development and to partner in youth violence prevention efforts both statewide and locally.

## State Performance Measure 5: *The rate of deaths per 100,000 adolescents aged 15 through 19 years caused by motor vehicle injuries.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 13.2 | 12.2 | 16 | 20.7 | 20.7 |
| Annual Indicator | 12.9 | 17.3 | 20.1 | 19.7 | 19.7 |
| Numerator | 317 | 435 | 515 | 516 | |
| Denominator | 2464390 | 2516412 | 2560575 | 2617630 | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 19.5 | 19.5 | 19.5 | 19.5 | 19.5 |

**Notes - 2002**

Numerators: State of California, Department of Health Services, Center for Health Statistics, 2002 California Death Statistical Master File. "Selected Injury-Related Sections of ICD-10" as modified by the National Center for Health Statistics, Centers for Disease Control and Injury Prevention and Epidemiology and the Prevention for Injury Control (EPIC) Branch, California Department of Health Services.
Denominator: Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, May 2004.
http://www.dof.ca.gov/html/Demograp/DRU_datafiles/Race/RaceData_2000-2050/California.txt
Tabulations were done by the MCAH/OFP Branch Branch.

**Notes - 2003**

Numerators: State of California, Department of Health Services, Center for Health Statistics, 2003 California Death Statistical Master File. "Selected Injury-Related Sections of ICD-10" as modified by the National Center for Health Statistics, Centers for Disease Control and Prevention and Epidemiology and the Prevention for Injury Control (EPIC) Branch, California Department of Health Services.
Denominator: Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, May 2004.
http://www.dof.ca.gov/html/Demograp/DRU_datafiles/Race/RaceData_2000-2050/California.txt
Tabulations were done by the MCAH/OFP Branch.
Rates for the years 2000-2002 may have changed from those reported in last year's report because they have been recalculated based upon updated population projections from the California Department of Finance. The new projections are based on the 2000 Census while data from previous reports were based on population projections from the 1990 Census.

**Notes - 2004**

A manual indicator is reported for 2004 based on 2003.

## a. Last Year's Accomplishments

The rate of motor vehicle deaths among 15-19 year olds declined significantly between 1990 and 2000, falling from 27.3 to 12.9 per 100,000. After increases in 2001 and 2002 (to 17.3 and 20.1, respectively), it declined slightly to 19.7 in 2003. The annual objective of 20.7 for 2003 was achieved. (Denominators are based on the number of adolescents, not the number of

miles driven. Numbers for the years 2000-2002 have changed slightly from those in last year's report because they have been recalculated based on updated population projections from the California Department of Finance. The new projections are based on the 2000 Census; numbers in previous reports were based on population projected from the 1990 Census.)

Differences in the adolescent motor vehicle death rate by race/ethnicity were as follows (2003): 22.2 for Whites, 19.9 for Hispanics, 17.6 for African-Americans, and 14.3 for Asians.

Motor vehicle injuries are the leading cause of death in California's teen population. The change from 12.9 in 2000 to 20.1 in 2002 represented an alarming increase of 56 percent in just two years, despite California's strong motor vehicle laws, including graduated licensing, zero tolerance for alcohol for youth less than 21 years, and primary seat belt law.

The use of alcohol by young drivers is especially dangerous. In 2002, 24 percent of young drivers (ages 15 to 20) who were killed in motor vehicle crashes were intoxicated. [58] Over the course of the last decade, the California Highway Patrol has increased enforcement of DUI (drinking under the influence / drunk driving) laws and has undertaken extensive education and public awareness programs. These include: "Sober Graduation," a program that targets high school seniors; the "Designated Driver Program;" "Red Ribbon Week," an annual event to increase the public's awareness of the problems associated with using illicit drugs; and the "El Protector" program which was established in response to the disproportionate amount of fatal accidents and DUI arrests involving Hispanic youth.

To raise funds to support child injury and abuse prevention programs, the State sells personalized auto license plates, called "Kid's Plates". Kids Plates feature a heart, hand, star, or plus sign. The proceeds fund child injury and abuse prevention programs. The Kid's Plates Program provides a wide range of technical assistance to help foster effective regional and local injury prevention efforts and funds grants for training and equipment. Between 1998 and 2003, over 200 grants were awarded to community-based organizations, local health departments, and other organizations. CIPPP is the Kid's Plate program administrator for the Epidemiology and Prevention for Injury Control (EPIC) Branch.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. The Center for Injury Prevention Policy and Practice (CIPPP) at SDSU provides technical assistance on injury prevention activities at the state and local levels and has helped develop the injury-related sections of the adolescent health plan. | | | | X |
| 2. The MCAH/OFP Branch works with CIPPP to organize the annual childhood injury prevention conference, which brings together a wide array of organizations, agencies, and individuals working in injury prevention. | | | | X |
| 3. Some local health jursidictions participate in programs promoting bicycle helmet distribution and education, promoting the use of seat belts, and discouraging teens from driving under the influence. | | X | | |
| 4. Some local health jurisdictions are using the Child Death Review data to identify trends and to raise awareness about deaths due to motor vehicle injuries. | | | | X |
| 5. To raise funds to support child injury and abuse prevention programs, including motor vehicle occupant protection and pedestrian safety, the | | X | | |

| | | | | |
|---|---|---|---|---|
| State sells special car license plates, called Kid's Plates. | | | | |
| 6. The MCAH/OFP Branch and CIPPP have applied for a CA Office of Traffic Safety Grant to investigate recent increases in the teen motor vehicle death rate and to disseminate information about best practices in decreasing teen motor vehicle deaths. | | | | **X** |
| 7. The MCAH/OFP Branch participates in the Statewide Coalition on Traffic Safety, which focuses on seat belt use and prevention of speeding and driving under the influence. | | | | **X** |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

The Center for Injury Prevention Policy and Practice (CIPPP), at San Diego State University, provides data and technical assistance in the development, implementation and evaluation of injury prevention programs and create linkages between agencies, researchers, and advocates. CIPPP provides information for local MCAH Directors on the availability and use of California-specific data sources for injury prevention. The information is posted on the CIPPP website with links to the actual data sources.

The MCAH/OFP Branch is working with CIPPP to organize the annual childhood injury prevention conference, which brings together a wide array of organizations, agencies, and individuals working in or concerned with injury prevention.

The MCAH/OFP Branch continues to fund selected counties for local injury control programs. Many counties are also participating in local SAFE KIDS Coalitions, child passenger safety seat checks and distribution, and bicycle helmet distribution and education. State law now requires that persons under 18 years of age wear a helmet while operating a non-motorized scooter or skateboard, in-line or roller skates or riding as a passenger on a non-motorized scooter or skateboard. Counties are also using the Child Death Review data to identify trends and to raise awareness for systems changes.

Money from the sale of Kid's Plates continues to support child injury prevention programs.

The MCAH/OFP Branch, in collaboration with CIPPP, applied for a California Office of Traffic Safety Grant to investigate the reasons for the notable increase in 2001-2002 in the rate of teen motor vehicle deaths, to develop local teen motor vehicle death maps at the county level, and to disseminate information about best practices in decreasing teen motor vehicle deaths. However, the Branch was not awarded the grant.

## c. Plan for the Coming Year

The MCAH/OFP Branch will continue to collaborate with the Statewide Coalition on Traffic Safety and other organizations. The focus areas for this coalition are seat belt use, speeding, and driving under the influence. The Branch also plans to work on the Child Death Review Council's Vehicle Occupant Safety Subcommittee.

The MCAH/OFP Branch is currently a member of the UC Berkeley Center for Traffic Safety's Teen Traffic Safety Task Force. The purpose of this task force is to put together a document summarizing both proven and promising practices to reduce teen traffic injuries. We plan to disseminate this document to our stakeholders.

CIPPP will continue to provide technical assistance on injury prevention activities at the state

and local levels.

State Performance Measure 6: *The incidence of neural tube defects (NTDs) per 10,000 live births plus fetal deaths among counties participating in the California Birth Defects Monitoring System.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 4.6 | 6.7 | 6.5 | 7 | 7 |
| Annual Indicator | 7.3 | 5.4 | 7.7 | 7.7 | 7.7 |
| Numerator | 43 | 32 | 47 | 49 | |
| Denominator | 58528 | 59027 | 60937 | 63305 | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 7 | 7 | 7 | 7 | 7 |

**Notes - 2002**

Source: State of California, Department of Health Services, 2002 California Birth Defects Monitoring Program Registry (CBDMP). The number of counties included in the registry was reduced beginning in 1998. Data since 1998 are from eight counties in the Central Valley. An analysis carried out by CBDMP of the neural tube defect incidence data from 1991-97 suggests the comparability of the 8 county sample with the larger sample used through 1997. The eight counties were deemed sufficient by CBDMP for surveillance purposes in this state.
Numerator: Confirmed cases of NTD in fetal death plus live births reported to monitored counties.
Denominator: Fetal deaths plus live births among counties participating in California Birth Defects Monitoring Program Registry.

**Notes - 2003**

Source: State of California, Department of Health Services, 2003 California Birth Defects Monitoring Program Registry (CBDMP). The number of counties included in the registry was reduced beginning in 1998. Data since 1998 are from eight counties in the Central Valley. An analysis carried out by CBDMP of the neural tube defect incidence data from 1991-97 suggests the comparability of the 8 county sample with the larger sample used through 1997. The eight counties were deemed sufficient by CBDMP for surveillance purposes in this state.
Numerator: Confirmed cases of NTD in fetal death plus live births reported to monitored counties.
Denominator: Fetal deaths plus live births among counties participating in California Birth Defects Monitoring Program Registry.

**Notes - 2004**

A manual indicator is reported for 2004 based on 2003.

## a. Last Year's Accomplishments

Between 1999 and 2003 the incidence of neural tube defects fluctuated between 5.4 and 9.1, with an incidence between 7.3 and 7.7 in three of the five years. The incidence for 2003 was 7.7, the same as the previous year. The annual objective of 7.0 for 2003 was not achieved. This incidence data, which is provided by the California Birth Defects Monitoring Program (CBDMP), is based on a sample from eight counties in the Central Valley.

The MCAH/OFP Branch continues its long-standing efforts to improve folic acid intake before and during pregnancy, because folic acid intake around the time of conception is associated with lower rates of neural tube defects (NTDs). The Branch continues to collaborate with, and provide technical assistance regarding folic acid use to, local MCAH programs such as BIH, AFLP and CPSP, other programs in DHS such as WIC, the Genetic Disease Branch (GDB) and the Nutrition Network, and outside groups such as the March of Dimes.

Information on the first National Folic Acid Week (in 2005) was distributed to all MCAH programs, state nutritionists and various other nutrition networks. This information included references to multiple resources on the importance of taking folic acid, along with information for ordering free brochures, posters, bookmarks, etc. In January the DHS Director referred to some of these resources as well, in the context of stating the importance of folic acid use in her Weekly Health Tip to all DHS employees highlighting Birth Defects Prevention Month.

In spite of efforts to improve folic acid use, findings from the California Women's Health Survey (CWHS) for 1999-2003 do not show improvement. The proportion of women of childbearing age (18-44) who report taking a folic acid supplement "at least some of the time" was stable from 1999-2003, hovering within three percentage points of 53 percent.

The CWHS findings further indicated that the following groups were significantly less likely to be taking folic acid "at least some of the time": Women who were less than 24 years of age, had low socioeconomic status, or belonged to a race/ethnic group other than non-Hispanic White. Just over a third of Hispanic women versus half of non-Hispanic women reported taking folic acid "at least some of the time." Findings also indicated that the primary source of knowledge about folic acid for Hispanic women was physicians.

Findings from California's Maternal and Infant Health Assessment Survey (MIHA) are consistent with those of the CWHS on racial/ethnic differences in folic acid use. MIHA findings indicated that Hispanic women were less than half as likely as non-Hispanic White women to take folic acid "every day or almost every day", just before getting pregnant. This disparity occurred every year the question was asked (1999-2002). In 2002, 19 percent of Hispanic women reported taking folic acid "every day or almost every day", compared to 45 percent of non-Hispanic Whites.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. The MCAH/OFP Branch produces and distributes pamphlets, posters, and other educational materials, in Spanish and English, which promote folic acid use among women of reproductive age. | | X | | |
| 2. The MCAH/OFP Branch collaborates with and provides technical assistance regarding folate use to local programs, including AFLP, BIH, | | | | |

| | | | | |
|---|---|---|---|---|
| and CPSP; and other programs in DHS, such as WIC, GDB, and the Nutrition Network. | | | | X |
| 3. The MCAH/OFP Branch and March of Dimes are working to acquire Vitamin Price Fixing settlement funds for a folic acid media campaign and folic acid education for providers. | | X | | |
| 4. The MCAH/OFP Branch has a representative on the National Council of Folic Acid and the California Folic Acid Council. | | | | X |
| 5. The GeneHELP Resource Center (Genetic Disease Branch) assists health care providers and the public with selection, utilization and development of accurate and appropriate educational materials on genetic screening, genetic disorders and services. | | X | | |
| 6. DHS provides information about folic acid in the booklet “Your Future Together”, which is distributed by marriage license clerks to all couples applying for a marriage license. | | X | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

Folic acid pamphlets and posters developed by MCAH/OFP continue to be distributed across the state via local MCAH and OFP programs, as well as GDB, all March of Dimes offices, and WIC. Folic acid promotion also continues through distribution and use of the CPSP guidelines, Steps to Take, CDAPP Guidelines for Care, and AFLP's Nutrition and Physical Activity Guidelines for Adolescents. The CBDMP, GDB and MCAH/OFP continue to provide information about NTDs and folic acid on their websites. MCAH/OFP's public health nutritionist continues to participate on both the National and the California Folic Acid Councils, as well as serving as liaison to all MCAH/OFP programs and other DHS programs.

Other current efforts include CDC's work on a rebuttal to the rejection of a collaborative grant proposal by MCAH/OFP and the California March of Dimes for vitamin price-fixing settlement funds to establish a statewide folic acid media campaign and a provider education program targeting Hispanic women. The rejection had cited an article written by CDC that was interpreted to mean that such programs were not effective. Though the money has already been distributed to other programs, CDC is writing in support of the proposal, providing another interpretation of the article cited.

MCAH/OFP Branch staff have given presentations on the CWHS findings on folic acid awareness and consumption in California to Branch staff and at CDC's annual MCH Epidemiology Conference in Atlanta, Georgia.

## c. Plan for the Coming Year

MCAH/OFP programs will continue their efforts to promote folic acid use among women of reproductive age. Since the Branch public health nutrition specialist sits on the National Folic Acid Council, California will again be directly involved in the planning of National Folic Acid Awareness Week in January 2006. Its resources and activities will again be highlighted on the MCAH/OFP Branch website. A document will soon be posted to the Branch website providing information on folic acid deficiency, folic acid sources, needs and recommendations, a perinatal nutrition assessment tool, nutrition education, referrals, and resources. Efforts are also underway to update the medical information on folic acid for the revision of the "Healthy Mothers Healthy Babies" booklet for new mothers, distributed by the Branch to county MCAH

agencies and community-based organizations.

Research work and dissemination of findings continue as well. A presentation on the CWHS work on folic acid use will be given at CDC's first Pre-Conception Care Conference in June, 2005. MIHA has reinstated folic acid questions in its 2005 survey. We will be analyzing those data in 2006.

State Performance Measure 7: *The percent of California Children's Services (CCS) enrolled children registered in CMS Net, the statewide automated case management and data collection system for CCS.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 48.0 | 29.0 | 34.0 | 45 | 55 |
| Annual Indicator | 23.3 | 36.3 | 41.6 | 50.5 | 55.1 |
| Numerator | 33969 | 57212 | 68911 | 87083 | 95100 |
| Denominator | 145717 | 157610 | 165710 | 172340 | 172510 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 60.5 | 100 | 100 | 100 | 100 |

**Notes - 2002**

This measure is the percent of CCS enrolled children under 21 years of age registered in CMS Net.
Source is CMS Net and CCS paid claims and program data for the reporting year.
Numerator is the number of CCS enrolled children under 21 years of age registered in the CMS Net system for FY 2002.
Denominator is the total number of CCS enrolled children under 21 years of age for FY 2002.

**Notes - 2003**

This measure is the percent of CCS enrolled children under 21 years of age registered in CMS Net.
Source is CMS Net and CCS paid claims and program data for the reporting year.
Numerator is the number of CCS enrolled children under 21 years of age registered in the CMS Net system for FY 2002-03.
Denominator is the total number of CCS enrolled children under 21 years of age for FY 2002-03.

**Notes - 2004**

This measure is the percent of CCS enrolled children under 21 years of age registered in CMS Net.

Source is CMS Net and CCS paid claims and program data for the reporting year.
Numerator is the number of CCS enrolled children under 21 years of age registered in the CMS Net system for FY 2003-04.
Denominator is the total number of CCS enrolled children under 21 years of age for FY 2003-04.

## a. Last Year's Accomplishments

SPM 07 was developed in response to the identified need to facilitate case management and coordination of care through a statewide automated system. The percent of CCS children entered in CMS Net was 36.3 percent for FY 2000-01, 41.6 percent for FY 2001-02, 50.5 percent for FY 2002-03, and is 55.1 percent for FY 2003-04. This indicator exactly met the performance objective.

Fifty-five counties were using CMS Net, following San Mateo County's conversion in early 2004. The three counties of LA, Orange, and Sacramento, with 44.9 percent of the active CCS cases, were not using CMS Net; however, work has begun to bring these three counties onto the statewide automated system.

E47 final development and implementation of the web-based system occurred over the past year. Implementation has been a huge activity for the CMS Branch. The help desk, as well as Branch staff, have been providing assistance to counties regarding the web-based system. The Branch conducted county and state CCS trainings prior to implementation of the web-based system, and held monthly teleconference discussions with the county CCS programs. A series of "This Computes!," an informational publication, has been utilized to keep the County programs and state staff informed as changes and modifications have needed to be made to the web-based system and as clarification of procedures has been needed. State staff have been meeting with Children's Hospital representatives to address their questions and concerns regarding changing their data systems so they can accept web-based authorizations. There has been much collaboration with Medi-Cal in the implementation of the web-based system. System development occurs with Medi-Cal. CCS procedural documents and lists are contained in the Medi-Cal Manual. Changes to any of these documents must go through the Medi-Cal process.

A CMS Net Users Group was convened in Sacramento in January 2005. Power Point presentations from the meeting were posted to the CMS website so that all county program staff would have access to the information. In response to questions from county staff, FAQs and answers regarding the web-based system and CMS Net have been developed by state staff and posted to the website. The FAQs are periodically reviewed and more questions and answers added as needed.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. There is continuing progress to convert the final three counties to the CMS Net system. | | X | | |
| 2. Conversion activities are ongoing, including trainings, site visits, implementation and post-implementation work. | | X | | |
| 3. Post-implementation work on the web-based system continues and dominates much of the work of the Branch. | | X | | |
| 4. Help-desk support continues for CMS Net and has expanded with the web-based system. | | X | | |

| | | | | |
|---|---|---|---|---|
| 5. There are ongoing teleconferences with the CCS county programs and regional offices regarding the web-based system. | | X | | |
| 6. “This Computes!”, an informational publication series is written by state-staff to inform county programs/regional offices of modifications to the web-based system. | | X | | |
| 7. State staff meet with children’s hospital representatives and other hospital representatives to discuss and assist in implementing the web-based system. | | X | | |
| 8. CMS collaborates with Medi-Cal on the web-based system. | | X | | |
| 9. CMS Net users group continues to meet. | | X | | |
| 10. Power point presentations and FAQs with responses regarding the web-based system have been developed and posted to the CMS website. | | X | | |

### b. Current Activities

Work continues to bring Orange, LA, and Sacramento Counties onto CMS Net. These counties will be individually brought onto the system. There have been delays in these county conversions because of the need to divert staff to the implementation of the web-based system and making system changes as needed.

Help desk support for all counties on CMS Net continues. Branch staff continue to hold teleconferences with the county programs to discuss questions and concerns. "This Computes!" continues to serve as an important method of communication with the state staff and county programs.

State staff continue to work with Children's Hospital representatives to facilitate their ability to accept web-based authorizations and to form a service code grouping that will address most of the procedure codes needed by CCS-approved tertiary hospitals so that individual codes do not need to be separately listed on the authorization.

### c. Plan for the Coming Year

There will be continuing progress to convert all 58 counties to the CMS Net system. Conversion activities include trainings, site visits, and implementation and post implementation work. There will be ongoing work on the web-based system implementation activities. Ongoing help desk support for all counties on CMS Net as well as those joining the system will continue and expand to address E 47 post implementation. State staff will continue to work with county programs, hospitals and providers in the implementation of the web-based system. Work will continue on expanding service code groupings as needed.

## State Performance Measure 8: *The percent of women 18 years or older reporting intimate partner physical abuse in the past 12 months.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 5.9 | 5.6 | 5.5 | 5.5 | 5.5 |

| | | | | | |
|---|---|---|---|---|---|
| Annual Indicator | 5.9 | 5.7 | 5.0 | 5.0 | 5.7 |
| Numerator | 611127 | 568216 | 492882 | 492882 | 629392 |
| Denominator | 10356460 | 9981232 | 9791029 | 9791029 | 11121430 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 5 | 5 | 5 | 5 | 5 |

**Notes - 2002**

Sources: State of California, Department of Health Services, California Women's Health Survey (CWHS), 2003. The percent refers to the percent of women in the survey who were 18 years or older and reported intimate partner physical abuse in the past 12 months, weighted to the 1990 census data. Some forms of physical abuse were condensed from separate questions in 1999 to a single question in 2000, 2001 and 2003.
Data from 2003 are presented for both 2002 and 2003 because the questions used in 2002 were not comparable to those used in other years. Also, rates of intimate partner violence were recalculated for all past years. In this recalculation, the denominator was redefined to exclude all respondents who either refused to answer or had missing data for all intimate partner violence questions.
Tabulations were done by the MCAH/OFP Branch.

**Notes - 2003**

Sources: State of California, Department of Health Services, California Women's Health Survey (CWHS), 2003. The percent refers to the percent of women in the survey who were 18 years or older and reported intimate partner physical abuse in the past 12 months, weighted to the 1990 census data. Some forms of physical abuse were condensed from separate questions in 1999 to a single question in 2000, 2001 and 2003.
Data from 2003 are presented for both 2002 and 2003 because the questions used in 2002 were not comparable to those used in other years. Also, rates of intimate partner violence were recalculated for all past years. In this recalculation, the denominator was redefined to exclude all respondents who either refused to answer or had missing data for all intimate partner violence questions.
Tabulations were done by the MCAH/OFP Branch.

**Notes - 2004**

Sources: State of California, Department of Health Services, California Women's Health Survey (CWHS), 2004. The percent refers to the percent of women in the survey who were 18 years or older and reported intimate partner physical abuse in the past 12 months, weighted to the 2000 census data. Some forms of physical abuse were condensed from separate questions in 1999 to a single question in 2000, 2001 and 2003 and 2004.
Tabulations were done by the MCAH/OFP Branch.

## a. Last Year's Accomplishments

SPM 08, the percent of women 18 years or older reporting intimate partner physical abuse in the past 12 months, was 5.7 percent in 2004, up from 5.0 percent in the previous year. The annual objective of 5.5 percent for 2004 was not met. These data are from the California Women's Health Survey (CWHS). In addition to monitoring prevalence, survey data are also used to better understand the characteristics of and risk factors associated with partner abuse among California women.

To combat the serious health threat of domestic violence (DV), the Battered Women Shelter

Program (BWSP) was established by legislative action in 1994 to provide comprehensive shelter-based services for battered women and their children. The MCAH/OFP Branch was designated as the administering entity for this program. BWSP provides a spectrum of enabling services to women threatened by DV. DV agencies provide shelter-based services, DV prevention projects, and projects to increase access to shelter services for unserved/underserved populations. Program goals and objectives are based on "Preventing Domestic Violence: A Blueprint for the 21st Century," a strategic plan developed by the statewide Domestic Violence Advisory Council, which is convened and facilitated by the MCAH/OFP Branch.

Over the years, the BWSP has evolved into a comprehensive domestic violence program. As part of this evolution, and as part of the MCAH/OFP Branch mission to protect and improve the health of women and children in California, the DV Program has released a request for application (RFA) promoting a comprehensive public health approach to address domestic violence. The RFA was released in August 2004, and the resulting contracts will be in effect from July 2005 through June 2010.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. The MCAH/OFP Battered Women's Shelter Project (BWSP) currently funds 97 shelter-based grantees to provide direct services to battered women and their children. | X | | | |
| 2. The MCAH/OFP Branch currently funds 32 domestic violence prevention/prevention planning projects. | | X | | |
| 3. The MCAH/OFP Branch funds 15 community-based organizations, with expertise in working with identified unserved/underserved populations, to develop culturally sensitive services that will increase access to services for these populations. | | X | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
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| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The MCAH Branch currently funds: 1) ninety-seven shelter-based grantees to provide direct services to battered women and their children, 2) thirty-two DV prevention/prevention planning projects, and 3) fifteen unserved/underserved projects. The unserved/underserved projects establish partnerships with community-based organizations that have knowledge and expertise in working with identified unserved/underserved populations; they work to develop culturally sensitive services that will increase access to shelter-based services for these priority populations.

Beginning in July 2005, 94 shelter agencies will be funded to provide a comprehensive program of direct services, prevention services and services for unserved/underserved. This is a change from the past practice of separate funding for prevention services and services for

unserved/underserved, a change which has been undertaken on the recommendation of the Domestic Violence Advisory Council. There will continue to be one technical assistance and training contract. Also, MCAH/OFP continues to participate in the CWHS to determine prevalence of DV statewide and to utilize the data for program funding determinations.

### c. Plan for the Coming Year

In August 2005 the MCAH Branch will convene a statewide meeting for BWSP grantees in conjunction with a meeting of the DHS Domestic Violence Advisory Council. The meetings are a collaborative effort to include grantee participation in planning and implementation. The statewide meeting will allow domestic violence shelter executive directors and their staff to help develop strategies for reducing the impact of domestic violence on victims' lives and to network, share information, and collaborate with leaders in government and non-profit organizations.

In the coming year grantees will be addressing a new standard on cultural competence. The DV Program established a Cultural Competency Advisory Committee to provide leadership and recommendations to the State DV Program on policy, standards and activities with respect to cultural competency. Each grantee, during the 2005-2006 funding cycle, will be required to develop a cultural competence policy statement and implementation plan. The DV Program plans to conduct regional trainings and technical assistance for the grantees in the area of cultural competence.

The MCAH/OFP Branch is working with BWSP contractors to implement automated program progress reports to facilitate a more efficient mechanism for program monitoring and data collection.

The Branch is currently working with the California Women's Mental Health Policy Council to involve the DV community in the Council's efforts to promote trauma-sensitive services, mental health services and substance abuse services which meet the needs of battered women. MCAH/OFP is also working with the Council to develop a curriculum for cross training DV advocates, mental health workers, and substance abuse counselors on services for battered women with co-occurring disorders (substance abuse and mental health).

State Performance Measure 9: *The percent of youth aged 12-17 years who report smoking cigarettes in the past 30 days.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 8.7 | 7.0 | 5.9 | 4.5 | 4.4 |
| Annual Indicator | 7.1 | 5.9 | 4.6 | 5.8 | 5.8 |
| Numerator | 207070 | 176813 | 143336 | 188000 | |
| Denominator | 2916475 | 2996832 | 3116003 | 3260000 | |
| Is the Data | | | | | |

| Provisional or Final? | | | | Final | Provisional |
|---|---|---|---|---|---|
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 5.5 | 5.4 | 5.4 | 5.3 | 5.3 |

**Notes - 2002**

Source: California Department of Health Services, Division of Chronic Disease and Injury Control, Cancer Control Branch,Tobacco Control Section, percent of youths 12-17 who report having smoked cigarettes in the past 30 days (year 2002) . The prevalence numbers are an estimate from random digit dial telephone survey results.
Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 1970-2040. Sacramento, California. December 1998.
http://www.dof.ca.gov/html/Demograp/Race.htm.
Numerator is an estimate derived by multiplying the percent by the denominator. Tabulations were done by the MCAH/OFP Branch.
.

**Notes - 2003**

Source: Percent of adolescents age 12-17 years of age who report smoking cigarettes in the past 30 days. 2003 California Health Interview Survey. UCLA Center for Health Policy Research. Also available at: http://www.chis.ucla.edu. Last accessed on February 24, 2005.

**Notes - 2004**

A manual indicator is reported for 2004 based on 2003.

## a. Last Year's Accomplishments

After a general decline in youth smoking over the course of the last decade, the percent of youth smokers rose in 2003. The prevalence of cigarette smoking among youth aged 12-17 years in California was 5.8 percent in 2003, up from 4.6 percent in the previous year. The annual objective of 4.5 percent for 2003 was not met. (The data source for this performance measure changed this year; the data point for 2002 was recalculated using the new source. The new data source is the California Health Interview Survey (CHIS). CHIS is a telephone survey, which tends to result in lower smoking prevalence rates than the rates from a school-administered survey.)

Among the four largest racial/ethnic groups, White and Hispanic youth had the highest smoking prevalence, at 6.2 percent. They were followed by African American youth at 4.5 percent. Asian youth had the lowest smoking prevalence, at 1.0 percent.

In 1988 California voters approved the California Tobacco Tax and Health Promotion Act of 1988 (Proposition 99), which increased the state surtax on cigarettes by 25 cents per pack. Twenty percent of revenues from the tax were earmarked for health education efforts aimed at the prevention and reduction of tobacco use. DHS was charged with conducting a variety of innovative approaches to reduce tobacco use, and the Tobacco Control Section was created. A few years later, in 1995, California's unprecedented statewide smoke-free workplace law went into effect.

The declines in youth smoking in California over the last decade are largely attributable to the tobacco tax increase and the long-term, combined effect on community norms around tobacco that resulted from the State's comprehensive tobacco control program. The program has included a statewide media campaign, a cessation help line (with tailored counseling for teens and pregnant women), approximately 100 local programs across the State based in local health departments and community based organizations, and the energetic efforts of four ethnic networks. These efforts reduced California's overall cigarette consumption from 1988 to 2002

at twice the rate of the nation; played an instrumental part in making virtually all indoor workplaces, including restaurants and bars, smoke free; and made tobacco in general less accessible, less acceptable, and less desirable among both adults and youth.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. The California Smokers Helpline, a project of the California Tobacco Control Program, provides tailored counseling services for teens, as well as for adults, pregnant women and chew tobacco users. | | X | | |
| 2. The California Smokers Helpline provides intensive tobacco cessation counseling, via the telephone, in English, Spanish, Korean, Mandarin, Cantonese, Vietnamese and for the hearing impaired. | | X | | |
| 3. Four statewide ethnic network projects, addressing the African American, American Indian, Asian Pacific Islander and Hispanic populations, conduct culturally specific educational and advocacy campaigns. | | X | | |
| 4. Local health jurisdictions coordinate information, referral, outreach and education activities within their jurisdictions; they also organize community coalitions to engage in community mobilization activities that promote social norm changes. | | X | | |
| 5. Local health departments and community-based organizations undertake activities such as educating pregnant and parenting teens about the effects of tobacco use and educating the public about tobacco industry strategies that promote tobacco use. | | X | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The California Tobacco Control Section of DHS has a variety of county, community, regional, and statewide smoking cessation projects. Each of the 61 health jurisdictions in California is responsible for coordinating information, referral, outreach and education activities within their jurisdiction. Each jurisdiction involves a community coalition to engage in grass roots community mobilization activities that promote social norm changes and educate the public about health issues related to tobacco use and tobacco industry strategies that promote tobacco use.

Seven statewide Priority Population Partnerships address the issue of tobacco control with California's African-Americans, American Indians, Asian/Pacific Islanders, Hispanic/Latinos, labor union members, the low socio-economic status community, and the lesbian, gay, bisexual and transgender community. They conduct culturally specific educational and advocacy campaigns, inform and educate community members and leaders regarding ethnic and class issues related to tobacco, facilitate community norm changes, and advocate for culturally relevant, population-specific, scientifically sound, community driven research that sheds light on tobacco related concerns in each community. Each Partnership provides technical support to the State, local jurisdictions, and community-based organizations on how to effectively reach

and work with priority populations.

The California Smokers' Helpline provides intensive tobacco cessation counseling, via the telephone, for those who are ready to quit, in English, Spanish, Korean, Mandarin, Cantonese, Vietnamese and for the hearing impaired. Tailored counseling services are provided for teens, as well as for adults, pregnant women and chew tobacco users. The Helpline provides self-help materials and a referral list to other tobacco cessation programs. The services provided by the Helpline are free of charge.

Lake and Modoc Counties provide examples of some of the teen-focused smoking cessation activities undertaken by local MCH jurisdictions. Lake County currently offers education to all pregnant and parenting teens about the effects of alcohol, tobacco, and other drugs, and partners with community agencies to collect data on drug and alcohol use in the MCH population. Modoc County's Teen Health Coalition, which has been active for eight years, focuses on tobacco cessation education and outreach, and is currently expanding to encompass other teen health issues.

### c. Plan for the Coming Year

The California Smokers' Helpline will continue to provide intensive tobacco cessation counseling via the telephone. The California Tobacco Control Section will continue its seven statewide Priority Population Partnerships addressing the issue of tobacco control with California's African-Americans, American Indians, Asian/Pacific Islanders, Hispanic/Latinos, labor union members, the low socio-economic status community, and the lesbian, gay, bisexual and transgender community. Local health jurisdictions will continue their smoking cessation activities, including outreach, education, referrals, and data collection and analysis.

## E. OTHER PROGRAM ACTIVITIES

Telephone Hotlines

Both the State and local MCAH jurisdictions have phone number/hotlines that provide information regarding maternal and child health services and programs. There are several statewide toll free telephone hotlines run by the State, including ones for MCAH and Baby-Cal.

BabyCal (800-BABY-999) provides information about the importance of prenatal care, practicing healthy behaviors during pregnancy, and the availability of state programs that can help pay for prenatal care services. Funding for the BabyCal media campaign and outreach publications was discontinued after June 2003, but the phone number is still in use.

In January 2004 the MCAH Branch added a hotline (866-241-0395) specific to MCAH services. It is staffed during office hours and, outside of office hours, is answered with a recorded message.

The number of calls to the BabyCal and MCAH numbers combined was nearly 20,000 in FY 2003-2004, down from 38,000 in FY 2002-2003. The decline is attributed to the discontinuation of the media and outreach campaigns for BabyCal.

Emergency Preparedness

DHS public health emergency preparedness efforts are consolidated in the Emergency Preparedness Office (EPO) to coordinate activities related to implementation of the CDC and HRSA bioterrorism grants as well as DHS's responses to natural disasters such as earthquakes, fires, and floods. EPO works with programs throughout DHS to prepare for and respond as needed to emergencies.

Under the CDC Bioterrorism Cooperative Grant, DHS allocates approximately 70 percent of funds to local health departments to implement local response capacity. DHS and local health departments share responsibility to assure that all focus area requirements under this grant are met, including meeting the needs of special populations. This responsibility is carried out in all grant activities, including development of state and local emergency response plans, risk communication messages, and training programs for local health department staff and the medical community.

Under the HRSA Bioterrorism Grant, 80 percent of direct service funds support preparedness and response activities conducted by hospitals, poison control centers, emergency medical service agencies, and clinics. To date, HRSA expenditures have covered personal protective equipment, isolation capacity, and hospital pharmaceutical caches to assure that medical personnel are protected during a bioterrorism incident. DHS has undertaken two projects to develop advisory materials and train medical providers in addressing the mental health issues Californians may experience during a bioterrorist event.

The CMS Branch has undertaken one of the mental health projects to assure that pediatric primary care providers have the necessary skills to care for the mental health needs of children. CMS is receiving $300,000/year for this four-year project which began in October 2003. CMS is collaborating with EPO and the Department of Mental Health to develop a training curriculum and training sessions that will link pediatric primary care providers, local bioterrorism networks, experts on childhood trauma, public and mental health agencies, and medical societies.

The MCAH/OFP Branch has hired an epidemiologist to develop surveillance capacity based on school absenteeism.

March of Dimes

The MCAH Branch collaborates with the California March of Dimes (MOD) on perinatal health issues. In addition to supporting research and advocacy efforts to accomplish this mission, the MOD invests in community services and education, with a specific focus on decreasing the disparities in infant mortality among ethnic groups.

The MOD is currently in its third year of an eight year Prematurity Campaign. The revised goals of the campaign are to 1) raise awareness of the problems of prematurity to 60 percent for women of childbearing age and 50 percent for the general public by 2010 and 2) Reduce the rate of premature birth from 12.1 percent in 2002 to 7.6 percent in 2010, in accordance with the Healthy People 2010 objective.

To meet these goals, MOD is collaborating with the MCAH/OFP Branch at the state and county levels to 1) increase awareness of the signs and symptoms of preterm labor through CPSP and BIH-based educational classes, clinic displays, and community events; 2) educate healthcare providers about prematurity risk detection and reduction through annual Prematurity Summits, the development and dissemination of tools to identify women at increased risk for preterm delivery, and Grand Rounds on smoking cessation during pregnancy; and 3) provide funding to agencies that are reaching high-risk communities with education and support services.

Additionally, Comenzando bien™, a culturally and linguistically appropriate prenatal education curriculum for Latina women, has been implemented and evaluated in a number of sites across the state. In the Central Valley, Comenzando bien™ boasts an 81 percent graduation rate and significant reported changes in behavior related to prenatal care, nutrition, and exclusive breast feeding.

This year MOD plans to revitalize the California Preconception Initiative (PCI)--Every Woman Every Time--a provider education packet that was distributed in California between 1999 and 2001. The MOD will collaborate with the MCAH/OFP Branch to evaluate the success of the past effort (by

determining if there was an increase in billing for preconception services) and plans to revise and redistribute the PCI materials across the state.

Nurse Family Partnerships

Nine counties in California utilize Nurse Family Partnerships (the David Olds home visiting model) to follow high-risk, first-time pregnant women, mothers and families. Several other counties have incorporated the work of Dr. Ira Chasnoff in dealing with fetal alcohol issues and perinatal substance abuse issues; most of these interventions include a public health nurse home visiting component.

## F. TECHNICAL ASSISTANCE

Methodological training in epidemiology and program evaluation

The MCAH/OFP Branch Epidemiology and Evaluation Section (MCAH-Epi) has an excellent staff of researchers and analysts for epidemiological analyses and evaluation of Title V programs. However, MCAH-Epi requests training for recent hires and junior research staff on several aspects of the methodology of epidemiological analyses of maternal, child, and adolescent health and program evaluation. The CMS Branch would also benefit from receiving training on these issues, including epidemiological methods, analyses of the cost-effectiveness or budget neutrality of programs, and the analysis of trend data. While it would be desirable to obtain this training directly through seminars and workshops offered at CDC, HRSA, and other Federal agencies, policies designed to address budget constraints in California prohibit out-of-state travel.

A workshop on epidemiology (e.g., risk ratios, sensitivity, specificity, validation, and bias) and appropriate statistical analyses commonly used in maternal, child, and adolescent health would be valuable to both the MCAH/OFP and CMS Branches. Applied examples, including examples of analyses commonly used by comparable state and federal entities, would demonstrate concepts and inform possible areas for enhanced analysis and program development. Many MCAH/OFP Branch programs are local; data collected at the state level may be useful for smaller areas, so an overview of small-area and geographic analysis would also enhance current and suggest future analyses.

Technical assistance on how to conduct cost-effectiveness, cost-benefit, and cost avoidance analyses for Title V programs would also be very beneficial for staff. During the current era of budget shortfalls in California, there has been greater scrutiny by decision-makers as to the cost-effectiveness and fiscal neutrality of programs run by the MCAH/OFP and CMS Branches. Technical assistance on the steps involved in analyses, parameters to consider, accepted methodologies, and effective presentation of results would supplement staff's ability to provide this critical information to program managers and administration officials.

Maternal Mortality

The CDC reports that more than 40 percent of women experience some type of complication during childbirth; many of these complications are preventable. Maternal morbidity is a serious public health problem that can impact maternal, fetal, and infant health and can lead to maternal death.

The MCAH/OFP Branch is working to monitor maternal morbidity. The MCAH/OFP Branch is developing a Maternal Quality Improvement (MQI) project and has contracted with an academic research group to assess variation in maternal outcomes and an evidence-based quality improvement collaborative to analyze the data. The MCAH/OFP Branch requests assistance in the development of systems for identifying, reviewing, and analyzing maternal morbidity that will serve as a framework for improved maternal standards of care.

The maternal mortality ratio for California in 2003 was 15.2 maternal deaths per 100,000 live births.

Mortality among African-American women was about three times higher than among non-Hispanic White women. The MCAH/OFP Branch will be conducting a Pregnancy-Related and Pregnancy-Associated Mortality Review Project under an agreement with the University of California, San Francisco. The goal of the study is to analyze causes of and risk factors contributing to pregnancy-related and pregnancy-associated deaths so that the MCAH/OFP Branch and its stakeholders can develop a public health component to reduce such deaths.

The MCAH/OFP Branch requests technical assistance from the CDC on how to conduct such reviews, including study design, data for linkages and case selection, medical record review protocols, guidance on determination of whether cases are pregnancy-related or pregnancy-associated, development of recommendations to reduce mortality based on findings, and implementation of recommendations.

Consumer Involvement - Youth

The MCAH/OFP Branch requests assistance in how to obtain youth input into decision-making for the Branch and its adolescent-related programs. Currently, the Branch does not have sufficient manpower to carry out this activity, but would like to include more youth input into our decision-making process.

Consumer Involvement - Families

Based on feedback given in a previous federal block grant review, the Branch requests training on consumer/family involvement in the needs assessment and other Title V activities at both the state and local level. This is a Title V requirement and the Branch has been asked to be more proactive in including families.

Evaluation of Clinical Outcomes

The CCS program has embarked on a quality initiative to assure that children receive appropriate services in an environment of dwindling financial and professional resources. The CMS Branch is requesting assistance in acquiring skills to develop and evaluate appropriate outcome and performance measures for clinical practice.

Strategic Planning and Facilitation

The CMS Branch has developed a collaborative relationship with the stakeholder community through the Title V Needs Assessment process, which is expected to continue with the development of strategies and activities as the next steps in the process. Additionally, there are issue-specific collaborations with families and agency partners to address and improve family-centeredness and client outcomes in the coming years. As the Branch moves into more infrastructure-building activities, it will be very helpful to have a core group of staff who are trained in strategic planning and facilitation techniques.

# V. BUDGET NARRATIVE

## A. EXPENDITURES

The budget and expenditures for FFY 2006 are presented in Forms 2, 3, 4, and 5.

## B. BUDGET

Since the enactment of OBRA 89, California has maintained the availability of Title V funds under both the maintenance of effort and the match requirements. The California Title V agency will continue to do so in the coming year.

The proposed allocation of Title V funds for California for FFY2006 is $47,947,194. Preventive and primary services for pregnant women, mothers, and infants are designated to receive $10,670,334 (22.25 percent of the total), preventive and primary services for children to receive $15,342,341 (31.99 percent), and CSHCN to receive $19,503,833 (40.68 percent).

State Match/Overmatch

California will receive $47,947,194 in Federal Title V Block Grant funds for FFY 2006. The required match is $35,960,395. California's FFY 2006 expenditure plan for MCAH programs includes $855,004,850 in State funds. Consequently, the state-funded expenditures for preventive and primary health care services for the Title V populations exceed the required 4:3 matching ratio.

Administrative Costs Limits

In FFY 2006, no more than 10 percent of the Federal Title V MCH Block Grant funds will be used for administrative costs related to each program component. During FFY 2006, California will expend only 5.07 percent of Title V funds on administrative costs.

Definition of Administrative Costs

In this Application, administrative costs are defined as the portion of the Title V dollars used to support staff in the MCAH and CMS Branch Operations Sections. Funds supporting State program and data staff (but not administrative staff) in the MCAH and CMS Branches are considered to be program rather than administrative costs.

Administrative costs include staff and operating costs associated with the administrative support of specific MCAH Branch and CMS Branch programs. These support functions include, but are not limited to, contract management, accounting, budgeting, personnel, audits and appeals, maintenance of central contract files, and clerical support for these functions.

"30-30" Minimum Funding Requirement

At least 30 percent of the MCH Title V Block Grant funds will be used for children's preventive and primary care services delivered within a system which promotes family-centered, community-based, coordinated care. At least 30 percent of the Title V Block Grant funds will be used to provide services to CSHCN delivered in a manner which promotes family-centered, community-based, coordinated care.

In some cases, the DHS uses estimates to assess expenditures for both individuals served and the types of services provided. These estimates are based on the target population and program activities authorized in statute, excluding the State budget, and specified in the scope of work for each

contractor. Requiring contractors to bill according to actual amounts spent on each type of individual served and by service provided is not possible within current administrative and fiscal policies. Changing State contractual policies would result in undue financial and administrative hardship to local governments and non-profit community-based organizations. This added burden without increased funding would result in many of them not being able to continue to provide needed services to women and children in the state.

Maintenance of State Effort

DHS has an ongoing commitment to provide maternal and child health services to women and children within the State of California. This commitment includes continued support to local health jurisdictions, local programs, clinics and Medi-Cal providers for maternal and child health services.

It is the State's intent to ensure that State General Fund contributions to these local programs, which are also funded in part by the Federal Title V Block Grant, be administered by the MCH and CMS Branches. The State's General Fund contribution for FFY 2006 is $855,004,850 which is $767,846,100 greater than the State's General Fund contribution of $87,158,750 in base year FFY 1989.

## VI. REPORTING FORMS-GENERAL INFORMATION

Please refer to Forms 2-21, completed by the state as part of its online application.

## VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

## VIII. GLOSSARY

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

## IX. TECHNICAL NOTE

Please refer to Section IX of the Guidance.

## X. APPENDICES AND STATE SUPPORTING DOCUMENTS

### A. NEEDS ASSESSMENT

Please refer to Section II attachments, if provided.

### B. ALL REPORTING FORMS

Please refer to Forms 2-21 completed as part of the online application.

### C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS

Please refer to Section III, C "Organizational Structure".

### D. ANNUAL REPORT DATA

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.